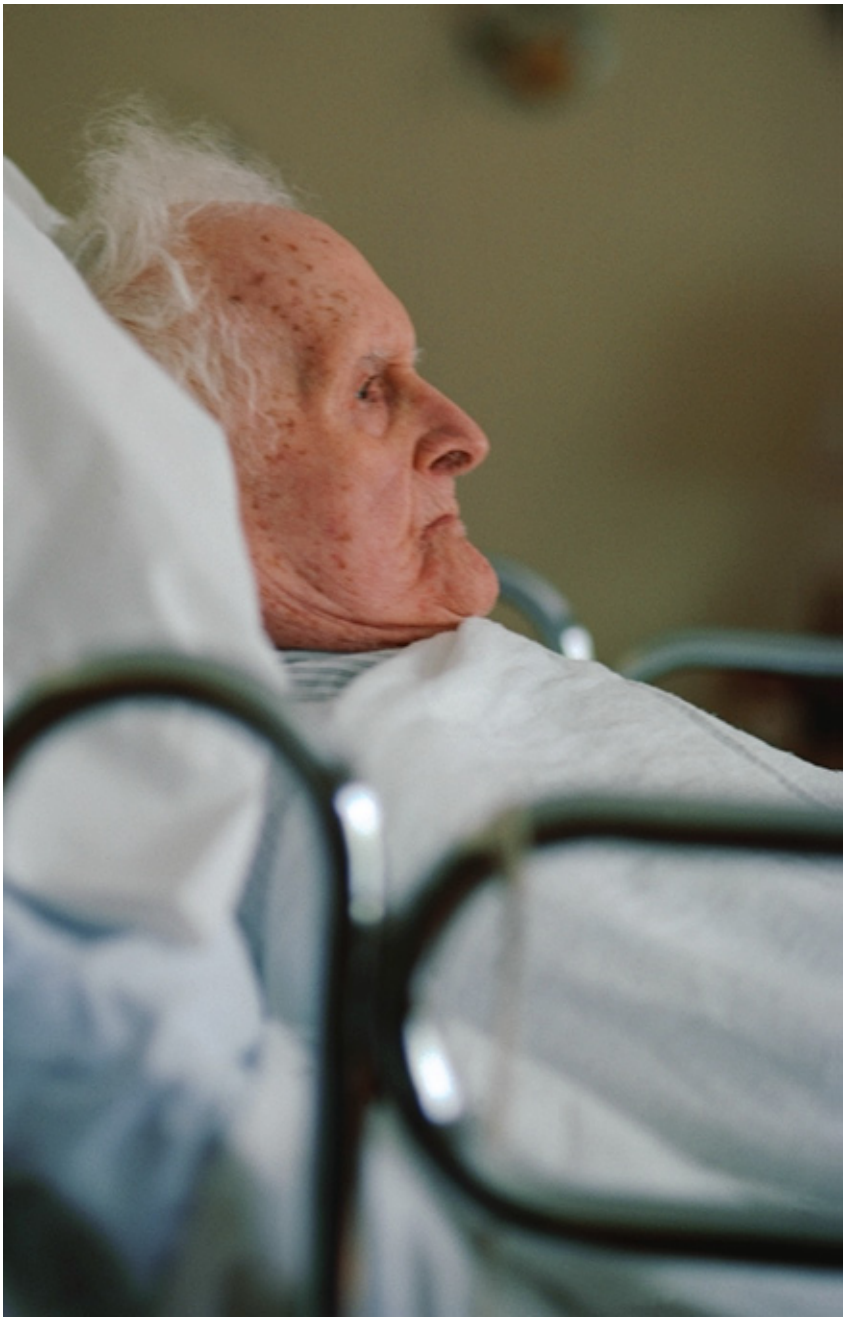
JOINT INFORMATIONAL HEARING
OF THE

SENATE COMMITTEE ON HEALTH
AND
SENATE SUBCOMMITTEE ON AGING AND LONG-TERM CARE



Senator Deborah Ortiz and Senator Elaine Alquist, *Chairs*

NURSING HOME QUALITY IN THE 21ST CENTURY: STAFFING ADEQUACY AND COMPLAINT INVESTIGATION

Sunnyvale Senior Center
July 20, 2005

STAFF:
Nicole Vazquez, *Consultant*
Robert MacLaughlin, *Consultant*
Lynda Hancock, *Committee Assistant*
Stephanie Yang, *Intern*
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CALIFORNIA LEGISLATURE

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of the
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SENATOR ELAINE ALQUIST: _____State Assembly and I'm pleased to do that again. I happen to live about ten minutes from here in the City of Santa Clara ...(gap in tape)... represent my senior community. And in years past, I was a senior in training, but I'm going to be 61 in August. And so I've been a member of AARP for years, and I no longer just smile and get away with saying I'm a senior in training. I'm getting to be a senior myself. My dear husband, Al Alquist, will be 97 August 2. He just had a complete physical a couple of weeks ago, got the report two days ago and nothing wrong with him. He had a great blood test, great chest X-ray. He's in great health, good mind, good spirit.

Anyway, welcome. I'd like to make some opening comments before we go into the panels. I'm going to try very, very hard—not just try but hopefully do it—to see that we run on time. I think it's important to give everyone toward the end of the hearing the same kind of time that we give people in the beginning. And so I will ask both of the panelists, and then when we go to open comment at the end, for people to be very concise in their comments, no need to repeat what someone else has said. And if you go on too long, I will, in a very nice way, ask you to stop.

So good morning, I'm Senator Elaine Alquist. I chair the Senate Subcommittee on Aging and Long-Term Care. You may recall that I recreated the Committee on Aging and Long-Term Care in the Assembly when it was originally created in the Assembly by Senator, then Assemblyman, Henry Mello many years ago and had gone inactive a few years and then we recreated that. On the Senate side, the Committee on Aging and Long-Term Care is a subcommittee under the Health Committee, so that's how it works there.

I'd like to say I know there are many people here who work in nursing home quality care, and I will also take a moment right now just to mention a few of our electeds. Mayor Dean Chu is here from Sunnyvale; John Warren, the Recreation Superintendent for Sunnyvale; Mark Stivers, Deputy Chief of Public Safety of Sunnyvale; and Tori Ueda, representing Assemblymember Rebecca Cohn's office. I'm sure there will be others joining us later, but I will not take time in the middle of things to be mentioning people.

Unfortunately, some of the other members of the committee will not be able to be here. But at some point, we will be seeing Nicole Vasquez, Senator Deborah Ortiz's consultant to the Health Committee, as we are putting this meeting on with the Health Committee, and I am also a member of the Senate Health Committee.

I'd like to thank the Sunnyvale Senior Center, Pat Lord and all of those who have made it possible today.

As you can understand, I've always championed rights for the elderly. My father was born in 1906, my husband in 1908, my mother in 1912. Both my parents have passed on, and my husband is almost 97 years old. I've worked on issues when it comes to quality of care for the elderly, for seniors for many, many years. Back in 1999, I had signed into law--back then a controversial bill--that actually took me two years to get it to go through both houses of the Legislature and get signed into law. It was AB 893, and it was signed into law in 1999, and it gave $100,000 so that DHS would document violations of nursing homes on the internet. I just found out

yesterday that that really has not been done, so that's another piece to the puzzle of why we are here today.

Also back in 2001, I co-authored legislation which required a minimum staff standard that guarantees 3.2 hours of direct patient care, per patient, per day and joint authored AB 1731, signed into law in 2000, which increased the serious fines in nursing homes from $25,000 to $100,000 Class AA violations for resident deaths, increased fines from $2,000 to $20,000 for Class A violations for a resident's health and safety, and willful falsification of patient health care records. And currently, I am authoring SB 526, a two-year bill.

The reason I'm authoring SB 526 is that it is really important that there be great accountability in state government and in this particular area, and I know we have representatives from the nursing home industry here today with us, and I say welcome. It's also really important, that when it comes to nursing homes, that we know really what is going on, that we have documentation on what is going on, and that that documentation is available to anyone who wishes to see that.

Some people would say to me, *"Elaine, you know, why do you have your bill right now, SB 526?"* They would say, *"You know, AB 1629 by Assemblyman Frommer gives all this money to help nursing homes."* And I think it's good to make this a priority to take care of our elderly, but I don't believe there is the accountability in AB 1629. It's the kind of accountability, had I been in the legislature—that was the two years I was out of office. You know, we have term limits in California, and so I was out of office two years, between when I ended my term in 2002 in the Assembly and then I was elected to the State Senate.

So there are things with AB 1629, in terms of the accountability, that we still really don't know about. And what I do know is that we're going to spend over a three-year period about $3 billion for care in nursing homes that will affect 1,400 nursing homes—1,400 nursing homes—in the State of California, and shouldn't we know what's going on there? As an aside, I also

sit on the Oversight Committee on Stem Cell Research and the way that initiative was written, it said after two years, state legislators really couldn't change the law. Well, we've held oversight hearings on that, starting with saying, *"You know, you're taking state taxpayers' dollars and we need to know what's going on."* Well, the same thing goes for right here with AB 1629. We, the public—and I'm part of the public, just like you are—we need to understand what's going on, and we need to see that care for the elderly is improved because, as great a place as California is, I think we still need to make great strides in how we care for the elderly. And so that's my opening comment.

Okay. I'll go back to my notes now, now that I said what comes from my heart here. AB 1629, Frommer, improves reimbursement under the Medi-Cal program to reflect the costs of adding staff to enhance quality by creating a new per-bed fee expected to generate $800 million annually for the nursing home industry over the next three years. It provides mechanisms for these expenditures. The mechanism allows for capital and administrative costs, and there certainly are costs when it comes to nursing homes. I understand that. Nonetheless, an unfortunate ramification has developed because of the passage of AB 1629. It has divided groups of advocates that had traditionally been unified on nursing home policy. And it's not because of a difference in final objectives—we all have the same final objectives—it's simply on how to get there. There is one commonality in these objectives, and that is to assure our nursing home residents receive the care that they need.

AB 1629 is the law of the land and provides a framework within which we must continue our efforts to develop and improve better public policy.

As mentioned, some of these other things about why I am carrying my bill. I should add also that only a small percentage of the state's 1,400 nursing homes meet the standards recommended for good care. Many show clinical signs of poor care, such as high percentages of residents who lose weight, are left in bed a lot of times, or are placed in physical restraints.

Many do not meet government compliance standards for care and safety, and a number have serious violations of both state and federal regulations.

My SB 526 will address what I believe are some inadequacies in AB 1629. For example, nursing homes report some staffing data to the California Office of Statewide Health Planning and Development, but the information is not audited for accuracy, nor is it available to the consumer in a timely fashion.

Next, the California Department of Health Services, DHS, collects limited staffing information during annual inspections, but it does not routinely verify the information. DHS does have the authority to cite and fine nursing homes for violating staffing requirements, but it has done so only in a handful of cases. And I want you to know that DHS is here with us because what I say regarding the issue I say publicly, and I'm prepared for whatever I say publicly to be on the front page of the newspaper and for anyone, including DHS too.

I believe in the continuum of long-term care services, from community-based services, in-home care, to the skilled nursing home, for those who need better kind of care. I want to make it clear—and I think those who know me well will understand this—I am not here to beat up on nursing homes—I don't think I have ever really done that—but I am here to say, that whenever any one of us has a loved one in a nursing home, I want to know if that person is getting the best care possible and not because I'm a state senator but because I'm a human being, and I want that for all of us and I believe we should get there.

Our task today is to bring together—to begin a stakeholder process to establish more accountability for new funds that nursing homes receive under Medi-Cal established by AB 1629.

So financing for nursing homes has its baggage _____, and I just think we need financing for it, but I wanted the accountability built in, and I think they will go a long way to bringing some credibility to the issue of what we're

trying to accomplish. Clearly, the Legislature has spoken with the funding of 3.2 hours of direct-patient care per patient, per day.

And with that, I would like to say thank you to all of you for being here; thank you for all of your work in this area. And we will begin with our first panel with Charlene Harrington, Associate Director of the UCSF John A. Hartford Center for Geriatric Nursing Excellence. I've worked with Charlene a lot when I chaired the Committee on Aging in the Assembly.

Welcome, Charlene. We're pleased to have you with us.

And Beth Capell has arrived also, and that is really good also. So let's see, we have Charlene Harrington who will be speaking first—I know she needs to catch a plane—and then after that, we will have Beth Capell, representative for SEIU, who will speak to the history of improving wages, staffing, and reforming the reimbursement system. So with that, welcome.

Charlene, would you like to begin?

DR. CHARLENE HARRINGTON: Thank you very much.

I have been working on nursing home issues since back in 1975 under the Jerry Brown administration, and I wanted to start off by saying that, at that time, we were concerned that approximately one-third of the nursing homes in California were not up to the standards. And I have wanted to say that_____the people of California...

SENATOR ALQUIST: Let's move the microphone a little closer to you.

DR. HARRINGTON: ...as a researcher at the University of California, San Francisco. We haven't seen much improvement in the quality of nursing home care in California in 30 years. I would like to argue today, but it has to do with inadequate staffing that we have in our nursing homes. And many, many research studies have been done over the past 30 years to show that one of the most important things is to have adequate staffing and that these studies are all confirmatory on the importance of staffing.

Now there's so many benefits from good staffing. It reduces the mortality rates, it improves people's ability to walk, it improves nutritional

status, reduces behavioral problems, it reduces your strength. All kinds of problems are directly related to poor nursing care.

Now there was a very important study done in 2001 by Dr. Schneid at UCLA, and that study showed, that for direct care, you need at least 3.0 hours per resident, per day, just to carry out five activities of daily living: eating, dressing, bathing, and toileting. So we know you have to have at least 3.0. The other part of this study in 2001 showed, that if you don't have adequate staffing, so many terrible things can happen to residents. They can go into congestive heart failure, electrol (sic) imbalance, respiratory infections, end up in a hospital; they have pressure sores, weight loss, and so many serious problems. So what we know is that we need to have 4.1 hours per resident, per day, at a minimum. The research shows that less than that has substantial jeopardy to health and safety of residents.

We did a study here in California of 34 nursing homes and picked nursing homes that have the highest staffing and the lowest staffing and high and low quality clinical indicators. And what we found was that most of the nursing homes in this state have poor quality care. Weight loss was a serious problem. Residents only got four to seven minutes of healthy eating. Most of the time, no one even talked...

SENATOR ALQUIST: Four to seven minutes?

DR. HARRINGTON: Yes.

SENATOR ALQUIST: A day?

DR. HARRINGTON: A meal. They should have at least 30 minutes.

SENATOR ALQUIST: It usually takes longer than that.

DR. HARRINGTON: Yes. And we found that they weren't being talked to. And in 12 hours, they were only being taken to the toilet 1.8 times. They should go to the toilet every two hours.

Residents were not being turned every two hours. They were being allowed to go back to bed and stay in bed 22 hours out of the day. They got very little walking assistance. Many were in pain all day long, and many have depression.

So we know from the research study that staffing was the best measure of quality of all of the measures that we looked at. On 13 out of 15 indicators, staffing was the key compared to other indicators. We found that facilities that have 4.1 hours had better feeding assistance, better help with residents in helping stay out of bed and better incontinence care. So we also believe strongly that there is a threshold, and if a nursing home does not meet that threshold, it's going to have jeopardy to its residents. Now we know it's not just a California problem. Nationally, 9 out of 10 nursing homes do not have those 4.1 hours.

We also know that the federal standards are completely inadequate for staffing. But for California, 3.2 hours is inadequate. We need to get those grades up to 4.1. We need that as a goal, and we need to encourage facilities to begin to employ that right away.

Now nationally, the average staffing is 3.6 hours per resident, per day. What has happened is a very frightening situation. The registered nursing hours have dropped 25 percent nationally since the year 2000. And in California, the registered nursing hours are also dropping. So here we have been promoting better staffing in the last 10 years and actually seeing it going down in terms of hours.

Now what's the situation in California? It is very serious. We have improvements, but 24 percent of nursing homes in California do not even meet the 3.2 hours per resident, per day. Now how can that be, after all this time, that that law was implemented and that was ordered of the nursing homes are not complying? We're not forcing them to do the minimal, and we know that it's inadequate.

Now when you look at how many are meeting the 4.1 hours that they should be meeting, it's 5 percent in California, 5 percent. So that means that if you want your loved one in a nursing home, you're going to have to look very long and hard to find one of those 5 percent.

SENATOR ALQUIST: How does the public know how to find that information?

DR. HARRINGTON: Well, there are two websites, the CANHR website and the California Healthcare Foundation. It's called calnhs.org. Both those websites show the stuff and consumers should look for good staffing.

Now we also know that this whole piece tends to over-report in their staffing data. One more point I wanted to make is that one of the reasons that staffing is low is that most of our homes are for profit, and they're cutting corners on faculty, trying to keep it low so they can make money, and this is a problem because we need higher staffing.

Facilities tend to over-report their staffing data. The data are often incomplete and incorrect. And, as you mentioned, there's very little auditing going on. So we think that SB 526 would be a good step forward because it would require payroll data to be submitted on a quarterly basis. Right now, the nursing homes only turn in their cost-report data on an annual basis and one year late. So that means the data is two years old. So we need timely data that's audited.

Those facilities that have 3.2 under that, I really think they should have holds on their admissions until they get their staffing up, and we should have some serious penalties for that group and then try to move to legislation over time to get up to 4.1 hours.

Another serious problem is the high turnover rate. We know that two out of three nursing personnel leave every year. Their staffing is very unstable, and this lack of facility causes poor quality, it causes incontinuity in care problems, it makes errors, factoring errors if they don't know the resident, there's fatigue and poor morale, and even higher injury rates are all related to these high turnover rates.

SENATOR ALQUIST: What do you think accounts for that high turnover?

DR. HARRINGTON: Okay. The key to the turnover is the wages. The wages are simply too low. We need to get the wages up. In 2003, they were $10.58 an hour on average. What we saw was a major increase in the wages for administrators over a two-year period but only a 6 percent

increase in wages for nursing assistants. So the wages are a big problem and the lack of healthcare benefits for the workers. That would help stabilize the workforce.

The other problem is that their workloads are too heavy because if they have to take care of 12 to 15 patients instead of seven, which it should be, six or seven per nursing assistant. They just are exhausted, and the care is poor. So we must reduce these terrible rates, and we must reduce their workload.

Okay. Now what happens, because we have this poor staffing, is we have a high number of deficiencies. Over 20,000 deficiencies were issued in California this past year for poor quality of care. In terms of looking at the federal deficiencies...

SENATOR ALQUIST: Can you explain, Charlene, what a deficiency is and who gives the deficiency?

DR. HARRINGTON: Well, the state that's serving the agency gives the deficiency for a violation of either federal law or state law. I have a graph here that shows that.

SENATOR ALQUIST: When this is done, who gives the deficiency?

DR. HARRINGTON: The state Licensing.

SENATOR ALQUIST: They are under DHS?

DR. HARRINGTON: Under DHS.

SENATOR ALQUIST: Thank you.

DR. HARRINGTON: So they're giving out 20,000 of these a year. That is a huge number for California. And then, when we look at the federal compliance, we see that only 8 percent of the nursing homes in California are in compliance under the law; 77 percent have serious noncompliance; 11 percent have very serious noncompliance; and 4 percent are completely substandard. Now this ratio has been the same for years and years. We're not getting care performing facilities. And it's going to continue to look like that if we don't do something about it fast. Also, we have over 11,000

complaints a year in California nursing homes. Again, that's directly related to inadequate staffing and poorly trained staff.

So just in summary, staffing is the best prediction of quality of care, but staffing in California is dramatically below what it should be to protect the health and safety of the residents. And one-quarter of all the nursing homes do not even meet the low 3.2 standard that we have. This leads to high deficiencies and high complaints, and the nursing homes are unlikely to raise their staffing levels on their own because they're trying to increase their net income.

I think we've got to get tough on nursing homes and force them into compliance or take them out of business if they're not going to comply with the law. (Applause) So in summary, I'd just like to say I would like to my strong support for your work on Senate Bill 525 to help improve the quality of care.

SENATOR ALQUIST: Thank you for coming, and thank you for all the documentation. Thank you.

Next we have Beth Capell, SEIU, on history of improving wages, staffing, and reforming the reimbursement system.

MS. BETH CAPELL: Thank you, thank you for having us here today. We are pleased to be here, and I'd like to say we've also been pleased working with Charlene Harrington over the years; although having to read all the staffing studies was rather like doing homework assignments, but we do concur with everything she had to say about importance of improving staffing and wages in nursing homes.

I'm going to begin not quite as far back as Charlene since I haven't been at this quite as long as she has. But I want to begin in 1998 when SEIU made an effort to improve quality of care in nursing homes to improve wages, staffing, and our reimbursement system. For us, these three themes have guided our work since 1998—improving wages because it reduces turnover and improves quality of care, improving staffing because it improves the working conditions of our members; and improves all of the

residents' quality of care, and dramatically revising the reimbursement system that has been in place in California since Ronald Reagan was governor quite a long time ago.

And I just want to take us through some of the accomplishments that we've all managed since 1999 because I think, as I was preparing for this hearing, we forget all of the things that have actually been done over the last seven or eight years. And I also want to note that much of this was done through the budget process rather than through separate legislation, and so you have to track this both through budget action as well as legislative action.

In the 1999-2000 budget, it was the 5 percent wage pass through for direct care to staff. Plus, we increased staffing to 3.2 nursing hours per patient day and finally got rid of the odd requirement that capped licensed nursing hours were doubled which obviously made it hard to tell what 3.2 hours was. In 2000-2001 budget, there was a 7.5 percent wage pass through. Also in 2000, AB 1731 was passed which included substantial enforcement requirements, which I know others who will talk it more than I will, but also required that there be a study of how to accomplish reimbursement reform.

In 2000, we saw Governor Davis propose a substantial increase in the number of inspectors in nursing homes for licensing certification. We also again saw a proposal in 2001 to improve substantially wages, this time through an innovative program called the "WARP" where nursing homes were required to have a legally binding commitment to pay increases in wages because they had failed so often to pay for each pass through to the workers as was intended. And so the work, which included another 8 percent raise in wages, was designed to improve wages once again.

Over the course of those years, the wages for nurse's aides in Los Angeles moved from $7 an hour to over $9 an hour. That is a very substantial improvement in wages that should have begun to help stabilize the workforce. Unfortunately, in the years since, because the work never

_____ because we've had bad budget years and because there's been a lack of increase, we have not seen further improvements in wages. So the progress we have made was sort of salt on _____ and that is a matter of deep concern to this union.

In 2001, AB 1075 passed, and I want to take up the other theme of improving staffing. We had increased staffing in the 99-2000 budget by requiring 3.2 nursing hours per patient day. AB 1075 proposes the improved staffing in a different way.

Currently in nursing homes, we require a certain number of nursing hours per patient day. Nobody knows what a nursing hour per patient day is. I cannot walk into a nursing home as a family member and walk up to a staff person and say, "*Have you done your 3.2 hours of care per day*?" This is not how people think about their work. It's not how a family member understands it. When DHS or any other entity attempts to measure it, there are all sorts of complications with doing that which we're going to hear, I suspect, quite a lot about today and on other occasions.

We instead propose that we do for nursing homes what we have already done for hospitals, which is require a staff-to-resident ratio. Now many of us are familiar with this on the hospital side. We have had in 30 years in California, after the Brown administration again, a requirement in our intensive care units and our operating room that there be one nurse to two patients in our intensive care units. This is readily understood, easily enforced, minimum, that nurses understand and family members can understand. We propose that DHS do the same thing for nursing homes.

This law has never been in--this provision of AB 1075 has never been implemented. And as best as we can gage, DHS is currently making progress toward implementing it. And we would encourage you. You know, it's hard—we have 24 percent of nursing homes or some chunk of them not meeting the nursing hours per patient day. Part of the virtue of ratios is anyone of us can walk into a nursing home and say, "*Okay,*" you know, "*the nurse's aide is caring for my family member. You know, you're supposed to*

have eight patients today. How many have you got? You're supposed to have four on the night shift. You're supposed to have 10 or 12. How many do you have?" SEIU in July of 2003 made a concrete proposal--we worked with Dr. Jack Shelly who's tried to devise it on what those ratios should be. To the best of our knowledge, no further action has occurred. We'll have to provide the committee and anyone else a copy of that proposal which has language since July of 2003.

So, we continue to be committed to improving staffing.

SENATOR ALQUIST: You have about two minutes left.

MS. CAPELL: Thank you and we'll continue to work on that.

With respect to AB 1629, we tried to build in accountability from the beginning. There were a number of organizations that were involved in devising that. We're happy to provide the committee a copy of the original SEIU proposal as well as the revised proposal that we developed with a number of other organizations.

We have not only the systemic cost centers, including cost centers for labor; we have also full audits every three years, limited scope audits, which are added as a result for this every year for facilities so we make sure that we don't have multiple years going by. We have the rate adjusted downward if a facility fails to spend. For example, if a facility gets $130 a day for care and they're supposed to spend $70 on staffing and they already spend $50, the rate will be adjusted downward in the future year to account for that.

The measure also includes four different evaluations, one by the Bureau of State Audits, a baseline evaluation, a report by DHS, and a sunset evaluation. Senator Ortiz, your colleague, attempted to include another evaluation. We literally couldn't figure out how to schedule it in before the sunset occurred.

With respect to staffing compliance, AB 1629 adds for the first time in statute the plain requirement that this be examined by audits, also a plain requirement that it will be part of the annual licensing process, and you add

that to the OSHPD data with all these inadequacies and lack of auditing. This is more scrutiny of staffing than there was before. We support additional efforts to assure that adequate staffing is there, and we also would support going to 4.1 nursing hours per patient day and look forward to the opportunity to do that.

With respect to 1629, I want to go back to the basic premise of the existing reimbursement system that has been in existence 30 years. This flat-rate system has no accountability. In Los Angeles, where the rate is $107 a day, if you, Senator Alquist, staff well, pay good wages, have nice food, make sure the facility is clean and the sheets are changed, you get $107 a day. And if I run a facility where we pay minimum wage, dump staff at 3.2, cut the orange juice with water, and don't bother to keep the place especially clean, I'd have $107 a day. And guess who's making money? You're not. I am. All the incentives are wrong in the flat-rate system

AB 1629 creates a system based on accountability with incentives to improve staffing and wages and with many provisions that are designed to improve staffing and wages, and we're happy to discuss at any length, at any time, with you or anyone else who's interested.

SENATOR ALQUIST: Thank you very much.

Next we have Willie Brennan, chief, Rate Development Branch, Medical Services, Department of Health Services, DHS.

Also, there are green cards on your chairs. There are green cards on your chairs. If you have questions, you should fill them out. If you have concerns you want to share, you can fill out a card, and then raise your hand and give your card to Mike--Mike over here--or Kansen on the other side.

Welcome.

MR. WILLIAM V. BRENNAN: Thank you, Senator.

SENATOR ALQUIST: Each speaker has 10 minutes, so be sure and save time for whatever is really important at the end here.

MR. BRENNAN: The Department has testimony in the back of the room that's provided. Two things—a little background history on the rates

and also where we currently are with AB 1629. I work in the Department of Health Services in the Rate Development Branch. I'm responsible for implementing AB 1629.

I want to go back to—I did it again—but 2000 was the first time we actually started looking at a new rate methodology. AB 1731 required the Department to actually hire a consultant to go back and review what other states do in review of new methodology. Then in 2001, AB 1075 was chaptered again. It required the Department to go back with this consultant to look at other methodologies for changing the current rate methodology system. We worked with a number of stakeholder groups. We had three meetings backing 2002 dealing with a consultant in a number of consumer groups.

Then in 2004, AB 1629 required the Department to implement this new rate methodology. One is to go back and unfreeze the frozen rates we established on August 1, 2003. As a result, the budget _____. In 2003, it was the first time in history we actually had not given a rate increase.

Another component was to add the quality assurance fee for August 1, 2004. It's a 3 percent fee on all nursing dollars in the State of California. Then on August 1, 2005, it was 6 percent.

The third component was to require the Department to develop a new rate methodology that's specific to each facility. This rate change required the approval by the federal government. And currently, the COLA, cost-of-living increase, has been approved by the federal government, the quality assurance fee waiver has been approved by the federal government, and the Department is still waiting for final approval on specific rate methodology. We submitted information to the federal government about five months ago. We received questions, and we're currently waiting for final approval of the specific rate methodology.

One of the things the Department has done in developing the new rate methodology, we held a number of work groups. Work groups were on the

long-term care industry, organized labor, seniors and consumers. And from these work groups we actually are developing this new rate methodology. Within the next month, month to month and a half, we should have new rates for all facilities, a new specific rate, and we hope to have seamless approval, federal approval, over the next 30 to 40 days. Our new rate system should go into effect, hopefully, on August 1 of this year.

SENATOR ALQUIST: Thank you very much.

Next we have Dave Helmsin. The reason we don't have everybody at the table is that I quickly realized that we have four seats and we have more than four people on the panel and I did not want to have anyone out. And hence, they are coming up one at a time. They all know they are on the panel. Okay.

Dave, welcome. Mr. Helmsin is the legislative advocate for the California Association of Health Facilities. And you will provide us with an historical assessment of the nursing home industry's perspective on the realities of compliance efforts.

MR. DAVE HELMSIN: Thank you, Madam Chair, for the opportunity to participate and for your continued interest in this subject area which is obviously of great importance to all of us.

I'm going to not talk about the reimbursement system as much as staffing because I think that's really the issue we want to point today. And I would start out by stipulating that we agree with the fact that staff is the key ingredient to quality, is the best indicator, and so forth. I would be remiss, though, without at least saying that the staffing levels that exist today are not solely a function of provider discretion. We're also subject to a reimbursement system that has its shortcomings, as you've heard, as well as a workforce pool that has persistent shortages which creates a multiple problem.

But that being said, there are a number of facilities out there and I think 24 percent is probably a pretty good number, that are not meeting the 3.2. The average staffing in California is 3.4, so they're also a great number

that are above the 3.2. If staffing is the best indicator of quality, then I have some good news. We are increasing our staffing and are improving our quality. In fact, we've brought staffing from an average of 2.9 in 2000 to 3.4 in 2003. Now that's a half a body per year, which may not sound like much, but it is about almost an 8 percent increase each year which is far more than Medi-Cal has funded. This industry has consistently spent more on staffing, wages, and positions every year than Medi-Cal has provided. We're constantly trying to catch up in reimbursement.

That puts California, by the way, about 24th in the nation on overall staffing, so we're pretty much in the middle of the pack, which is not where any of us would like to be. There is a problem with the data. I agree that the data is flawed in a number of areas, although I think it's understated. So that's an area we need work on, but there are a number of factors—how you treat salaried employees, some of the temporary help, private nursing, and other things—that don't go into a calculation on the 3.2.

Noncompliance is not something we're proud of. It's something we work every day to avoid. But just to put it in some perspective: The average nursing facility has about 35 employees a day, direct-care employees. And if you've got one employee missing for the entire day, you drop a tenth of an hour on your staffing. If you're 100th of a tenth off of your staffing, you're still out of compliance with 3.2. So it's intolerable in terms of the standard. But as a practical matter, it's not out of line with what a normal business's vacancy rate is. Once again, we fight every day to get folks there.

We've heard that the enforcement is lax on the staffing. I'm not sure that we understand that. We think that the Licensing and Certification Division has a body of state law, federal law, and a good deal of policy that directs their oversight of staffing.

We've heard that their staffing, meaning L&C reductions, taken over the year, have compromised their ability to do their job, which we also don't

understand that. We fund L&C through license fees so the facilities know what we pay in fees every year.

SENATOR ALQUIST: You might describe "L&C" for those that don't know what it means.

MR. HELMSIN: I apologize. The Licensing and Certification Division of the Department of Health Services, which is, I would argue, probably the primary enforcement tool that we use in California.

SENATOR ALQUIST: And they're not here today?

MR. HELMSIN: The problem there is that, once again, L&C has a $90-million-a-year budget for long-term care oversight. They have over 600 positions involved in overseeing care in 1,200 freestanding nursing homes and then obviously the smaller community-based facilities. But it's not a resource problem there, and the resources have not been decreasing. We've seen our rates for license fees increase each year for the last four years. So I'm not sure that the vacancy factor can be blamed, if there is a problem. I'd also point out that 1629 that we've heard so much about added over nine positions to L&C to look specifically at staffing.

Right behind L&C, you've got the Audits and Investigation Division. We heard a little bit about what they do. Sixteen twenty-nine also added—excuse me—they redirected positions within the Department to accommodate the workload for 1629, and that was determined in the legislative discussions.

You've also got—I'm just talking kind of like oversight here. You've also got OSHPD in the loop. And OSHPD does not do audits, but they are the keepers of the data. They've got a sophisticated system for doing accuracy assessments. They do work with providers to make sure the data is accurate. And then when you get to the more serious levels, we've got the Department of Justice with its operation, Guardian. We've got the Office of the Inspector General. Those folks are out there routinely overseeing nursing homes.

Sixteen twenty-nine, as we've heard, added a couple of reports and some other oversight which I think will help address the problem. When

there is a problem, there is an absolute plethora of sanctions that can be applied. The Department can and does use both state and federal citation and deficiency systems, and the operations run everywhere from directed training to $10,000-a-day fines. So these are not lightweight sanctions at their disposal. The AG and OIG, of course, could file criminal charges.

So with all of this, you know, we're not happy to be here today talking about lingering dissatisfaction over the staffing problem, and we agree it's there. We think there's some things that we can do and that should be done, and I would start with data. I think we share in agreement with everybody that's looking at this that better data is a good thing, and we believe that the current data has got limitations in its timeliness, accuracy, and comprehensiveness. So what we would like to propose in that regard is, as a part of 1629, the implementation process, we have got some supplemental reports being developed. Now we can still impact those supplemental reports and should impact those to collect the kind of data we need for better staffing assessment. And I think we would agree, or at least our thinking is, that you could probably go to something that's verifiable against payroll, against other things you file, like your employment development, unemployment insurance, your federal taxes, and so forth. So we think we can create a very accountable level of data through those supplemental reports. We think it ought to be timely. We're not opposed to quarterly reporting if, in fact, we can get the reports designed in a way that they're electronically submittable. Then quarterly reporting may make sense. And we also think they should be comprehensive and that all the stakeholders should have a voice in designing the stuff that they collect.

SENATOR ALQUIST: I have a question.

MR. HELMSIN: Yes.

SENATOR ALQUIST: What policies or industry standards does your organization endorse or promote in order to encourage industry-wide compliance with state and federal laws?

MR. HELMSIN: We are the primary trainers of facilities and staff in California, and we dedicate a huge amount. We have a foundation that we fund, and numerous employees that provide training throughout the state regularly on all the requirements, including staffing, and we also worked with EDD, the Employment Development Department worked with Workforce Investment Boards, the Employment Training Panel, and others to get staff into this line of work and to try to urge the facilities who conduct most of the facility-based trainings where the staff get the training. So without us, there would be very little coming out in terms of workforce.

Back to 1629, just for a minute, we think that this is the first systemic attempt to address the staffing problem. We agree that it will realign the incentives so that you have providers who are incentivized to spend money on wages and staffing within some limits of restrictions, but it will take away the distance end of it as existed in so many years and has developed the type of behavior that people are criticizing.

I would point out—you know, we heard a little bit from Charlene on nonprofit versus profit. I mean the difference in those two entities is not just a name. They have different realities as well. And by the way, the profit, the most recent data for profits in the nursing homes in California, is 1.8 percent, which is lower than any other industry, any other health provider. You could do a lot of other things with your money that will pay far better than running a nursing home.

That being said, if you look at the patients in those facilities, you'd better be thankful we have for-profit nursing homes. They're taking care of your Medi-Cal patients, they're doing it for less money than the nonprofits, and they're actually doing it with less resources, unfortunately, as a function of the reimbursement system.

We think we ought to implement 1629, get the reports, get the oversight that's in place to manifest what the issues really are, and then we'll be in a better position to do policy changes. Until that time, we wouldn't be recommending any changes in the enforcement area. We think

we can reevaluate all the standards, the staffing levels, oversight, everything, with a much more informed decision making in that time.

I would say, though, that nothing in 1629 waived any of the current enforcement requirements for the 3.2, and the Department, I think, has resources in place. They've got the mechanisms and the sanctions, and nothing in this bill and nothing in this change will preclude them from doing what they need to in that area.

SENATOR ALQUIST: You have about a minute.

MR. HELMSIN: Quickly, to wrap up on the quest for higher staffing, I mean we hear 4.1 as an objective, and I'm not sure there's any provider out there that wouldn't like to have more staffing at his facility or her facility to take care of the patients. If we've got 1629 up and running and it does fix the Medi-Cal reimbursement problem to the extent that we think it will, that's a good step, but it's not everything. We have other payers—Medicare. We dodged a huge Medicare bullet which was going to cut nursing home significantly this year. We've also got a proposal out of the administration to move most of this to managed care, and managed care makes their money by not paying providers. So we have a problem that we need to protect rates in that transition and assuming we get it all right and you've still got the training capacity and the workforce shortages to deal with.

Just to put it in perspective on workforce, California ranks 49th in the nation on RNs per capita. It's no wonder we're dropping RNs in nursing homes. In fact, the 87 percent of the active nurses, RNs, are employed right now. And the BRN, the Board of Registered Nurses, estimates they need 100,000 or more to fill the gap over the next few years.

SENATOR ALQUIST: And in closing...

MR. HELMSIN: In closing, I would just say that we're happy to work with you and other stakeholders to improve the quality of nursing home care. That's our profession, that's what we do for a living, and we'd like to do it well. Thank you.

SENATOR ALQUIST: Thank you very much. Thank you for being here.

As the next speaker comes up, who is Alan Robison, as he comes up, I'd like to welcome the Vice Mayor of Sunnyvale, Ron Swegles and also, Nicole Vasquez from Senator Ortiz's office. Senator Ortiz is Chair of the Senate Health Committee on which I serve, and this hearing is a joint effort between the Senate Health Committee and then the Subcommittee on Aging and Long-Term Care, which I chair

I'd also like to thank the Sergeants. I personally really appreciate what you do in having us, in being able to hold these hearings in an orderly fashion, and thank you very much.

Okay. Mr. Robison is supervising Deputy Attorney General, Elder Abuse Prosecuting Unit, California Department of Justice. He will speak to the need for verifiable staffing data in elder neglect prosecutions involving nursing home operators and the data needs of California's chief enforcement entity.

Welcome.

MR. ALAN ROBISON: Thank you, Madam Chairman. With me as well is Charles Raborn who is one of our senior investigative auditors because he has actually been involved in the process of trying to calculate staffing and has some comments about the difficulty in trying to do it with the present data.

I should mention that the bureau we work for is the Bureau of Medi-Cal Fraud and Elder Abuse, and we investigate and prosecute patient abuse and neglect in the state's long-term care facilities. So we do have a lot of experience in this particular area. And what we would say is that the most important factor determining the care that the patients receive at the nursing homes is staffing. So we think that that is very critical or very pleased that you're having this hearing today looking at staffing.

I can actually give an example of a case where the poor staffing resulted in egregious neglect of the patients. It's a case that we prosecuted

both criminally and civilly against Beverly Healthcare Corporation which is the nation's number one nursing home chain. And at the time we were prosecuting them, they were the number two chain in the state of California. They own the Beverly La Cumbra facility in Santa Barbara, and the facts that occurred there took place in 2000. We convicted them in court on July 31, 2002. And because of the lack of staffing they had at the facility, and we took all the census records as well as the punch detail reports from the facility, and we looked at it for the year of 2000, to look at the staffing. And the first thing I can tell you is it took an enormous amount of time. Basically, you're looking at one auditor having to spend months in order to figure what the staffing was for one facility for one year.

What we concluded was, for the year of 2000, it was 2.7 for that year. In particular, in some of the critical months, May through July, it was 2.5. So what you had was scores of patients who were not getting turned, for instance, who were bed-fast patients, and they developed pressure ulcers.

SENATOR ALQUIST: I have a question. How do you reconcile the data, you know, 2.5, 3.2, 3.4, 2.7? How do you make sense of it? How do *you* make sense of that?

MR. ROBISON: It was difficult for our auditors. We basically followed the policy and procedure manual of the Department of Health Services L&C. And so we, for instance, gave credit to the MDS, or minimum data set operators. Even though they're not involved in patient care, we followed the L&C guidelines. We went ahead and gave them credit for that. But we had to actually look at the employee and try to determine what they did at the facility so we could see if they were seeing CNAs or LVNs, if they were involved in direct-patient care. Like I said, it's terribly time consuming in order to do that for one facility for one year, and what we found was that the short staffing led to these pressure ulcers.

One patient in particular was a woman named Laura Simmons who was 102. And starting in January 2000, she developed severe pressure ulcers on her buttocks region and her feet due to the poor nursing care. Her

condition worsened until by May of 2000 her right foot went gangrene. Finally, on July 23, 2000, maggots were discovered between and underneath the fourth and fifth toes on her right foot.

We have a description here of one LVN that had to deal with these maggots and the pressure ulcer. And this is a quote from her, when we went and interviewed her. She said: "When we entered the room, there were small flies everywhere like there were rotten fruit in the room. As they removed the bandage from Simmons' foot, flies flew out of the bandage in the wound. There were hundreds of them. The smell was terrible, like something dead. There were maggots on top of the foot, between the toes, on the bottom of the foot, and crawling in and out of the wound. The maggots were big and fat. I took a long Q-Tip and probed into a large golf-ball-sized bubble on the upper foot pad of the foot. I pushed on it to flatten it out. It broke open. It was full of maggots. I scraped the maggots off the foot and legs. The more I would dig into the foot, the more maggots came out."

Laura Simmons was transferred on July 28, 2000, to an acute-care hospital where she died on August 1 of 2000. We criminally convicted the corporation of elder abuse, 368(b)(1) for that. We also had a civil filing as well of unfair business practices. That's an example of where short staffing leads directly to abject neglect of the patients.

What we would suggest is, what we need to do is focus on how to efficiently enforce the staffing standards we have in California. And the way that you do that, you can't have one auditor spend months for one facility, just for one year. We need to make it simple to calculate the staffing. Right now, it is not simple to calculate whether or not the facility is in compliance with 3.2.

What we have been doing is looking at OSHPD reports in order to try to see compliance. And we would suggest that OSHPD report...

SENATOR ALQUIST: Would you say what OSHPD is for people?

MR. ROBISON: Oh, yes. Thank you very much.

When I say "OSHPD," I'm referring to the Office of Statewide Health Planning and Development, and the all the facilities every year have to file a report with them where they give a lot of staffing information. And that would be an efficient way of checking the staffing of the various 1,400 facilities in the state. And Charles Raborn will speak briefly about some problems that we've encountered with that. There's some information there that's not broken out, such as MDS hours.

One thing that we're particularly concerned about as well, in terms of the industry trying to reach 3.2, is the way they've been cutting back the RN hours. That's one way that they've been getting closer to 3.2 because the RNs, of course, cost more, and so you can cut RN hours and hire more CNAs. The problem is that you really need those RNs there at the facility, and we've tracked the decline. Just looking, for instance, going from 2001 to 2003, we've had to take OSHPD data and calculate it ourselves because it's not available. And we've seen that for large facilities, 100 beds or more, in 2001, it was 0.351 RN hours. And now in 2003, it's .335. So we're very concerned about the reduction of RN hours.

Now I'm going to turn it over to Mr. Raborn who's going to talk about his work trying to calculate 3.2.

MR. CHARLES W. RABORN, JR.: Madam Chairman, as Mr. Robison said, I'm an investigative auditor with the Bureau of Medi-Cal Fraud and Elder Abuse.

When I was attached to this unit, my task that was laid in front of me was for several cases, and it was essentially to evaluate the performance of some entities as to whether or not they had been able to both not only comply with injunctions that had been in place but also that they were in compliance with the mandated staffing levels. My first—and also what they were doing in performance to their peers in the industry.

One of the things that I did was I looked and tried to find where the 3.2 was officially issued in terms of reports, where these facilities are officially evaluated and where the 3.2 compliance numbers come from. Of

the ones that I was able to determine at Department of Health Services, OSHPD and so forth, OSHPD was the most reliable and the best source of data for my use. But when I tried to evaluate the 3.2, the data that OSHPD collects, the way the form that it collects the information and the form that presents it, has some inherent problems.

For example, the Department of Health Services has a memo that says that the MDS operators count towards direct care. That information is captured and recorded on the OSHPD report in the "Other" category or, I should say, the technicians and specialists, which that category does not count for direct care. So we're combining hours that count in a column that does not count for calculation purposes. It is also allowed that directors of nursing time counts towards direct care for facilities that are between sizes of one and 59 and they separate their time. But then again, we have part of the time that counts in the management and supervision line which traditionally does not count, and the part of it in the RN line which does count. And where I'm going with this is that it's extremely difficult to break this information out for one facility or, I should say, one corporation that we're looking at that has multiple facilities. And when you're trying to look at it in terms of...

SENATOR ALQUIST: Doesn't direct care mean direct care? (Laughter) They're supposed to spend their time on direct care. It doesn't mean administration. It doesn't mean training nurses. It doesn't mean—it just means direct care...

MR. RAYBORN: I would agree with you, Madam Senator, that that's exactly what it would mean. It would not mean doing paperwork...

SENATOR ALQUIST: But I wouldn't be surprised _____ definition. Well, we can talk more about that at some other time.

MR. RAYBORN: Okay. I would welcome the opportunity.

MR. ROBISON: I think we are in agreement that 3.2 should be looking at direct-patient care, not administrative. But the OSHPD report as currently construed doesn't just doesn't break it out. The other problem

here, which is really not a punishment, is to make the facilities fill out OSHPD reports accurately and timely or even to comply with 3.2. There's nothing specifically in the statute that requires 3.2 that spells out what happens if they don't comply with it. So that's another thing that we think that OSHPD should look at. Thank you very much.

SENATOR ALQUIST: Thank you very much.

Okay. Next we have Robert Goldsborough, resident of a local nursing facility. Welcome, Robert. Thank you for being here with us today.

MR. ROBERT GOLDSBOROUGH: Thank you so much. Good morning.

SENATOR ALQUIST: Good morning.

MR. GOLDSBOROUGH: My name is Robert Goldsborough, and I have been a resident of long-term facilities in Santa Clara County for 15 years. I am currently a resident at Winchester Convalescent Hospital and president of the Residents' Council there. Thank you for the opportunity to testify.

Patients at long-term healthcare facilities are being cheated out of the care that they need. Nurses and CNAs have too many patients.

What does it mean when your care attendant has too many residents, especially for high-care maintenance patients, like myself? It means that they cut corners either with me or with other patients. It means, if the attendant takes time to do something for us, things that should be done, we are being reminded that they are taking time from someone else. I'm constantly being reminded that "*You're not the only patient,*" and "*You think you're king.*"

It means the attendants either do a complete job quickly, sometimes resulting in physical injury, like patients being thrown against the rails, or they eliminate tasks moving onto the next patient.

In my case, it means that attendants are not careful with supersensitive patients who are in lots of pain. When you are experiencing chronic pain, the way you are handled can increase or reduce that pain. If you can't move the way your body is arranged and the frequency with which

you are turned affects that pain. And with increasing pain, the longer you experience the pain, the less—it gets more intense. And when they finally do get care and therapy, it's less effective. It takes a longer time for you to get back to feel less pain.

Failure to be turned not only increases pain but also leads to bedsores and death. I had two bedsores several years ago. My lawyer and I needed to demand that the facility take proper care of me. Thank God I have a lawyer. _____. Thank God for her.

When attendants have too many patients to take care of, they stop caring for their patients. They don't have the time to be kind. They just need to get their work done, and so they end up making their own priorities. And just what takes priority? Paperwork, not resident care.

There's a quote here: *"If it's not on paper, it hasn't been done."* In our experience, what's on paper has nothing do with the care we get. This is especially true of care conferences, which they're supposed to have every quarter for each patient. You go in and they're supposed to decide what your care is going to be.

SENATOR ALQUIST: And you have that every quarter?

MR. GOLDSBOROUGH: Yes. It's scheduled for every quarter, but most patients, after they go to two or three of those, they just get discouraged because what they write down on paper gets tucked away and filed to be saved for the licensing _____.

SENATOR ALQUIST: So you have no sign-off of whether the task was accomplished? No sign-off?

MR. GOLDSBOROUGH: Not for me. I haven't seen anything.

When the caregivers have too much work to do, they'll lie about what they did. They may only brush your teeth maybe once a day, at the most, sometimes five times a week. They never floss; sometimes they won't shave you; and sometimes they don't get you up in time for activities. Twice I was sent to the hospital because I was dehydrated. They kept telling me I should drink more water, and then they never came around to give me

water. So my urine became too concentrated. When I came back, I realized I had to take things into my own hands, and I went around to various stores and bought different parts and put them together and had my home-water delivery for my bed and my wheelchair. _____.

Also, the problem I had was, I had a suprapubic tube, which is a tube going directly into my abdomen. It needs to be cleaned every day and changed every month. I went to the hospital for six weeks and it was black at the end of it.

I think, if you need something done, you have to beg and make demands and you soon get the reputation as being a demanding patient. And God help you if you try to tell your student aides or nurses how to take care of you. There's been hundreds of deaths since I've been in this condition for 17 years _____, as if 150 hours can train for a caregiver is not enough to take care of a high-care patient like myself. And training caregivers is a never-ending task because of a high turnover rate, 82 percent and sometimes as high as 200 to 300 percent. Unfortunately, many caregivers are immigrants who don't speak English very well. It's really difficult to expect that they can care for me when I can't move my hands or point to things. And what about patients who can't speak? Patients who are comatose? And many patients just don't know what their rights are concerning patient care.

When there are not enough caregivers, residents don't get care and caregivers get burnt out. Being a caregiver, a nurse, or CNA is not an easy job, and they don't get paid enough. And many caregivers, they work a 16-hour double shift. Either they work double where they're at now, or they work at two different facilities, eight hours at each place. And I questioned almost everyone who's ever taken care of me and they're all like that.

Those caregivers who do care, work very hard. Some caregivers who work really hard are chastised by other caregivers, "*You're working too hard; you're making me look bad.*"

SENATOR ALQUIST: You have about one more minute.

MR. GOLDSBOROUGH: Attention should be placed on not only how many caregivers there are, but how good they are and what they do. Like we need to have someone always in the dining room because if a patient falls or is choking, then it's left up to other patients to go find a nurse some place. One time it took 15 minutes for that to happen.

Something needs to be done about the conditions at convalescent hospitals. They shouldn't need to be a choice between documentation to providing actual care. We need adequate staffing, we need to make sure staff does the work that we need, and facilities need to be held responsible when they don't.

Thank you very much, Senator Alquist, for your untiring efforts to improving the quality of our care.

SENATOR ALQUIST: God bless you, Robert.

MR. GOLDSBOROUGH: God bless you.

SENATOR ALQUIST: I'd like to take a moment here to say, too, before we have the Consumer Sound Board that I appreciate the work that people do to provide care providers. I know that is not easy. And what we think—one reason I'm holding this hearing and one reason I do the work in elder and senior and disability care that I do is that we need to see that people who provide the care are paid well. To me, that's a big issue because many of the things that happen—and we're going to be hearing about some of the things that happen—happen because there just aren't enough care providers in a facility or a home and that they're not paid as well as they should be, and Mr. Thompson is a friend of mine. And I just really believe that people who take care of those in great need need to be paid fairly. And it seems like, I look at what we did on IHSS this year, we had to fight tooth and nail just to see that—the Governor wanted to take IHSS to minimum wage that that did not occur, and that did not occur. We had to fight so hard for that, so hard. In a civilized society, which for the most part we are in California and America, for the most part, that should not have to be the case.

Next we have a part that is little new to me. It's called the "Consumer Sounding Board." If you will bear with me a little bit, as I find exactly how this is working. There are two people for this part, and Gary Passmore is first. And then we'll have Sherrie Matza. Gary, I know he's here.

Welcome. Hold on. One more minute. Okay.

And if you could take about a minute each, a couple minutes each, that would be great.

MR. GARY PASSMORE: Okay. Thank you, Senator. I'm Gary Passmore, Congress of California Seniors. Before I begin, le me wish your wonderful and esteemed husband, Al Alquist, a happy birthday about in about ten days; 97 is an inspiration for all. (Applause)

SENATOR ALQUIST: Yes, thank you.

MR. GARY PASSMORE: Senator, I posed your question that I'll get to in a second. I just would like to make an opening statement about it, and that is...

SENATOR ALQUIST: Actually, it sounds like there are only two people for this part; is that true? So you each may get three minutes.

MR. PASSMORE: Oh, okay. Thank you.

I think you heard from all of the panelists this morning, a very deep concern about care of patients that are in skilled nursing facilities in California and a widespread commitment that we make changes that improve that quality of care, and we appreciate your leadership in this effort.

Assembly Bill 1629 made a huge step in that regard last year. It committed what I consider to be enormous resources, especially in light of the constrained physical situation that the state faces. As I understand it, your bill, 526—and this hearing, this process, is designed to examine whether or not the accountability that exists right now under state law is adequate, that we can all be comfortable that those new resources and the resources that are already being spent are being monitored and we know what we're getting for our money, and I agree, absolutely. That should be one of our top priorities.

I think in that regard, what we need to do is ask ourselves whether or not we need new law—new safeguards, new standards—or whether what we have in place today is at least adequate for the present and what we to do is enforce the law that we have.

SENATOR ALQUIST: Right. And we need to look at both.

MR. PASSMORE: Exactly, exactly, and I think then we need to look at the resources that are required for the enforcement. I think in some larger way we've looked at the resources that might be required for better quality care in 1629. So I guess that would be an opening topic that I'd want to make.

The nature of my question that I forwarded has to do with this issue that came up with several speakers about how we track staffing, how we track staffing hours, or hours per patient day and so on. And I guess I'd like to hear from some of the other panelists who were here earlier, if we have time, from that fellow from SEIU, Mr. Helmsin. Charlene Harrington, I guess, has already left. But maybe, if we could follow up with her and ask her to get back to us something in writing about this issue, about the way we measure and how they might go about measuring the staffing and comparing that. The issue came up in the Attorney General's Office.

SENATOR ALQUIST: If it's all right, why don't we just ask them to come up in just a minute? Mr. Helmsin and Ms. Capell.

Is there someone else you wanted to see?

MR. PASSMORE: It was Charlene Harrington. I think she's left. We'll just forward and maybe can get some information.

SENATOR ALQUIST: If you could just each speak literally a minute to explain how you come up with the staffing.

MR. PASSMORE: Well, it has to do with how we track and measure the number of hours and the staffing and whether or not there are other ways to do this and better ways perhaps.

SENATOR ALQUIST: Okay. Two minutes each.

MS. CAPELL: With respect to the 3.2 nursing hours per-patient day, let me first again make clear that from SEIU's perspective, we think ratios are a smarter way to do this. Having said that and having said that we regret that that law has not been implemented which I will continue to say until it's been implemented, with respect to the nursing hours per-patient day, we concur that the OSHPD data is not as accurate, not as timely, and has the flaw of being self-reported, unaudited data. That having been said, it is one resource with respect to information about adequacy of staffing.

Secondly, AB 1629 requires that in the annual licensing survey for the first time—in the annual licensing survey—that DHS review the compliance with the 3.2. It also requires that audits look at that as well. DHS had been doing some of this on its own voluntarily; 1629 codifies that, and one would hope that they would comply with the law.

I think with that, I will...

MR. HELMSIN: I would only add that I don't believe that there is a problem of validating the staffing if you're on site and you're a reviewer or an auditor because you have access to all the payroll records, registries, sign-ins, everything. It's the facility's burden to convince you that they staffed appropriately. So I don't think it's a problem at that level. What I think is a problem—and what I've heard here and other times—is that it's not readily accessible to consumers as a useful tool for evaluating the facility and that the OSHPD data, while it's available, has some flaws.

SENATOR ALQUIST: That's not easily available on _____.

MR. HELMSIN: I believe it's translated to a couple of websites that we heard about. And it is actually—they do a pretty good job in arranging and providing the data they have. But I think we're all of one mind that the date, one could be refined a little bit because now we're focusing in more on staffing and, two, to the timeliness is the issue. By the time you get OSHPD data, it's a couple of years old. I think everybody would like to have a quicker reference for staffing assurances.

SENATOR ALQUIST: Thank you very much.

MR. PASSMORE: Thank you, Senator.

SENATOR ALQUIST: What we're going to do next is we have Sherrie Matza from the Alzheimer's Association. She would like to speak. Then I would also like to invite Donna DiMinico who's in the Long-Term Care Ombudsman Program for San Clara County. She's the program director. I'd like to ask Donna, if she's still here, to come up also.

So Sherrie could come up. Would you like to make some comments?

MS. SHERRIE MATZA: Yes. Thank you, and thank you for holding this hearing. My name is Sherrie Matza, and I'm involved because I took care of my mother for almost a decade in my own home who had Alzheimer's disease and then had to place her in a nursing home. So I'd like to comment on a couple of things that I heard here today.

One, I'd like to react to, the whole issue about staffing in a skilled nursing facility. And while I appreciate everything that everybody said, when you have a situation, you're already just meeting whatever that requirement is. And as you heard from one of the panelists, somebody just doesn't show up that day, well, that's too bad, but businesses have to deal with that every day. Businesses don't have to deal with that every day because they don't have to deal with the possibility of somebody choking because you don't have enough staff or somebody becoming dehydrated or even dying. It's not the same as somebody who's not there to take a trade in a brokerage house.

SENATOR ALQUIST: It's literally life and death.

MS. MATZA: It's life and death. Thank you for allowing me to react to that, and I'm sure that was jus t a comment, but I picked up on that.

You heard from a man who had daily experiences living in a skilled nursing facility. And here's somebody who can articulate his own needs. What about the person with Alzheimer's disease or another dementia who is so cognitively impaired or even has no cognitive ability at all? How are those needs...

SENATOR ALQUIST: Or who doesn't speak English.

MS. MATZA: Doesn't speak English, which is a very common occurrence for someone who is from a country with another language and maybe spoke English beautifully or certainly well enough to get along in this country when they were cognitively able to. But once they go into the despair of Alzheimer's disease, they could very possibly lose that second language, so that's an excellent point. So what happens to them?

I want to address the issue about consumer data as well. Being a consumer and thinking that I'm a relatively smart person, but I can make no sense of data. What I want as a consumer is I want the professionals who are in the field to be able to do the kind of research that I heard here today, to come up with what is that best standard. Tell us, tell the residents of California, what that is and tell us in simple terms how to find that.

I don't have a horror story to tell. My mother was in a good nursing home. But as one of the panelists said, how does that consumer know what those hours are? She's right. I saw that there was someone sitting with my mother. And I said, *"Well, I can see the same person every day when I go."* The particular nursing home that I had my mother in had low turnover. I was extremely fortunate. Maybe they're one of that 5 percent up there that has the good staffing ratios. But I saw the same people every day and that made a difference. After five years in a nursing home when she died, it was her caregivers who hugged me and cried with me. So I can only say I hope that you continue your work. I think that this is vital, and I volunteer with the Alzheimer's Association, and I know that we will provide you with anything that you need.

SENATOR ALQUIST: Thank you and I want to thank you for coming forward because we need to hear the examples of good nursing homes and good care that is provided. Also, I think you made a great point, and that is—and I say this to my staff a lot when we deal with a lot of situations with constituents—I say, *"How do you know the right question to ask if you don't understand?"* How do you know? I think that for many of us, that's a big

issue, you now. How do you find the information on which nursing homes—because there are some doing a very good job that are meeting the ratios that don't have the documented violations. But how do most of us really know? And I believe the state—that we need to provide that information to the community?

MS. MATZA: Yes. I agree. I also think that—again, I appreciate all the work that the caregivers do, that the nursing home industry does in large part. But as with so many things, we're only as good as our weakest link. So that's why, from what you've heard from the man with Elder Abuse, we've got to pay attention very seriously to those issues.

SENATOR ALQUIST: Thank you very much.

Is Donna DiMinico here? If she'd like to come up just briefly. We want to thank you for what you're doing. Would take like to take just a minute to share with the group what you do?

MS. DONNA DiMINICO: Thank you, Senator. I'm the Program Director for the Santa Clara County Long-Term Care Ombudsman Program, and we do advocacy for the people in the nursing homes.

SENATOR ALQUIST: And do you have cards with you?

MS. DiMINICO: I do.

SENATOR ALQUIST: After we're through, do you want to step over by the door? Some people want to talk to you.

MS. DiMINICO: Thank you. And thank you for giving me a minute or two to speak to you on the staffing issue.

_____ residents did refer somewhat to _____. I think that training the staff is going to increase the numbers to make it adequate, means the staff needs to be adequately trained. And knowing that sometimes the language may only be a superficial barrier, I think that people do not understand how to care for a resident with different needs, different conditions—you know, I know that the investigator spoke of the Beverly La Cumbra facility. But it seems to me, that when the staff's trained to understand the importance of a pressure sore or what the possible outcomes

could be and being invited as ombudsman to deliver training to staff that they are _____ services or whatever, I think that when you bring people into a room—and it's unfortunate they do not speak the same language as the presenter, even as you're standing _____, we have to be able to train people in a way that they can do their job very well.

SENATOR ALQUIST: Do you have people who can explain, who can translate into different languages?

MS. DiMINICO: Some of the facilities are able to provide a translator, and we have a couple of people who speak other languages on their staff. But I think the facility's responsibility is to be able to do that training so that the individual staff members are able to understand. Having had a grandmother who lived to almost 102 and for the last five months of her life went to a nursing home and spoke clearly and did not need assistance to express her need, you know, when I'm sitting there and she's asking me to put the little salt packet on her tray, and what happens is, is the care plan says she's on a NAS, no added-salt diet, why is the salt packet on her tray? The staff who was packing the tray didn't understand that whole—you know, for her to go to _____ the salt was not a big thing. But that's just a minor, personal experience.

You know, I love my job, and I appreciate the work that the staff do in facilities. Three point two never speaks to consumers, that it be individuals talking about going to their care plan. My staff member, who's also here, said that at a care plan meeting, the social service person and the medical records person were the only staff people at the residence care plan. So something's wrong with some of the training and interaction...

SENATOR ALQUIST: _____. Is there anyone here who would like to talk with Donna? Feel free to step by the door.

MS. DiMINICO: Thank you.

SENATOR ALQUIST: Thank you very much.

We will now go to the second panel, Status of the Complaint Investigation and Enforcement System. And we will start with William

Brennan, Chief, Rate Development Branch, Medi-Cal Care Services, Department of Health Services, DHS, who will speak to the Licensing and Certification Branch of DHS, an assessment of the L&C role in assuring compliance with current and emerging state policies.

So I understand that you will be speaking for Licensing and Care?

MR. BRENNAN: That is correct, Senator. I represent the rate side for Medi-Cal program. We provide a _____ on all professionals on the L&C side _____.

SENATOR ALQUIST: Okay. So no one from L&C is here?

MR. BRENNAN: That's right.

SENATOR ALQUIST: So no one from L&C is here. I know that you spoke before. Did you want to make any comments...

MR. BRENNAN: We have written testimony that L&C has supplied.

SENATOR ALQUIST: There are packets on the table for anyone who would like to see it. I'm assuming that we have a copy also. Okay. And I know you're hearing this. You spoke earlier, so thank you.

Well, Patricia, that gives you a little more time.

MS. PATRICIA L. McGINNIS: Yes. I'll try to save my time for consumers because I know this is an extension of the morning where many, many consumers have...

SENATOR ALQUIST: And this is Patricia M^{c}GINNIS, Executive Director of California Advocates for Nursing Home Reform, who will speak to the historical perspectives of the development of existing complaint investigation systems, purpose and goals of California law and regulations, and the current state of California's complaint and abuse investigation system. Welcome.

MS. M^{c}GINNIS: Thank you, Senator Alquist, and the committee consultants. I really appreciate the work you put into this, and I thank you for the opportunity to address the problems of California's Complaint Response and Enforcement System.

Before I begin, I just want to say a couple of things, I guess, about AB 1629. I can't help it. I think that we have to remember, AB 1629, for those who are new here today, or new to this issue, it creates a new rate reimbursement system. And primarily, it's about money and money alone. Whether or not there will be additional staffing, whether there will be better wages, all those wonderful goals that we heard today will be realized, I hope, for the sake of residents. I hope the faith that the union members have put in this bill is realized, very, very much. It didn't happen in 2000 when the industry got all that extra money under the Aging with Dignity Act. So I think that it has to be remembered, SB 526 is about accountability. It's about ensuring what the promise of 1629 promised, ensuring that that is, in fact, delivered.

Anyway, having said that, I'm going to talk about the enforcement system and really put the focus on the Complaint Response Units as are proposed by SB 526. My organization, California Advocates for Nursing Home Reform, has been monitoring profits with California's nursing homes and addressing consumer concerns for almost 23 years—over 23 years now.

California's enforcement system for nursing homes, under the auspices of the Department of Health Services' Licensing and Certification Unit, has a long and checkered history. Numerous studies, reports, reviews since the 1970s have found inadequacies in enforcement and failure to respond to consumer complaints.

California's Little Hoover Commission examined the state's oversight of nursing homes in 1983, 1987, 1989, 1991, and probably even longer than that. In every case, the Little Hoover Commission issued reports critical of the Department's nursing home oversight and enforcement activities and issued recommendations for reform.

In a scathing 1998 report submitted by the U.S. Senate Committee on Aging—or submitted to the U.S. Senate Committee on Aging—the General Accounting Office found that oversight of California's nursing homes was

inadequate to protect residents with serious care problems and, in fact, placed residents in danger of death or serious bodily harm.

Subsequent reports issued by the Special Investigation Division of the U.S. Representatives' Committee on Government Reform in 1999, 2000, and 2003 found that less than 3 percent of the nursing homes in Los Angeles were at full or substantial compliance with federal standards, that only 6 percent of Bay Area facilities were in compliance, 19 percent of the facilities in Los Angeles and over 33 percent of the Bay Area nursing homes had violations that caused actual harm to residents or placed them at risk of death or serious injury.

Now I mention this because, remember, 2000, 2003, that's when the rates, the wages in Los Angeles facilities had also gone up as a result of Governor Davis's Aging with Dignity Act. So we can't necessarily equate better wages with better enforcement or better care. It's not necessarily so. If we don't have an enforcement system, the rights of the residents and the better care is not necessarily going to follow.

A July 2003 GAO study found that serious weaknesses in state survey, complaint, and enforcement activities continue to exist in most states, including California. In fact, the GAO report noted that California was among those states that showed a marked decline in the issuance of serious deficiencies. You will note Dr. Harrington this morning noted we had over 20,000 deficiencies issued in 2004. But what we really have to realize is that the majority of those deficiencies were understated, that they were not more serious deficiencies, that they did not pick up the real serious problems that we have in nursing homes. The number of actual harm or serious jeopardy deficiencies issued against California nursing homes declined almost 20 percent in a one-year period. While it would be comforting to think that this decline could be attributed to better quality of care—certainly we'd like to think that—the GAO study indicated that this decline was actually due to the understatement of actual harm deficiencies.

So how did the Department of Health Services respond to these critical reports and recommendations? I would suggest that the facts and the statistics speak for themselves.

The Department of Health Services' Licensing and Certification is responsible for licensing nursing homes, for completing annual surveys, for investigating complaints, and through its enforcement efforts to ensure compliance with state and federal laws and regulations. The state has a wide variety of state and federal remedies to choose from. State enforcement tools include a system of deficiencies, citation, penalties, bans on admission, placing the facility in receivership, or even suspension and revocation of the facility's license. For facilities that participate in the Medicare or Medicaid programs, federal programs, the state can recommend a variety of federal enforcement remedies as well, in addition to the state sanctions. The failure of our enforcement system in California can be seen very directly in the downward trends and citations in California and the understatement of the scope and severity of deficiencies, and at a very infrequent use of federal and state enforcement measures.

SENATOR ALQUIST: Can you speak to AB 892, which we worked on together, which was my bill to put documented violations of nursing homes on the internet?

MS. M^{c}GINNIS: Well, it hasn't happened. It's one of many, many things that hasn't happened in California.

SENATOR ALQUIST: And that requires DHS to do that.

MS. M^{c}GINNIS: That's correct. Now DHS has said that they're working toward it. We got a memo that they were going to have internet information available in March. Then we got, no, it's going to be delayed.

SENATOR ALQUIST: Since 1999 on this particular issue.

MS. M^{c}GINNIS: Well, they had quite an obligation since the early '80s to provide consumer information as well from their district offices. That hasn't happened either. What we did get is such blank material, it's

absolutely useless to consumers. So that's just one part of what's not being done in California.

If we look at citations, which is generally the most frequently used enforcement measure in California, the Department issued fewer citations and assessed fewer civil monetary penalties in 2004 than in the history of the citation system in California. Only 484 citations were issued against California nursing homes, and with numerous opportunities for facilities to appeal, probably less than 50 percent of the fines that are assessed would actually be collected.

Another measure, of course, is the federal deficiencies and remedies. The Department has told us over the last year, *"Well, the reason why you're not seeing so many state remedies and state citations and state deficiencies is because we're really focusing on federal deficiencies."* And in fact, we've seen that sharp increase. We've seen a number of federal deficiencies go up from 13,000 something to 19,000 something, and they can issue these deficiencies by scope and severity, depending on the violation. So although the number of federal deficiencies has risen to almost 19,078 in 2004, most of these deficiencies do not reflect the seriousness of the violations. And then because of that, few federal remedies are imposed. So despite what the Department of Health Services said, according to the data that we receive from the Centers for Better Care and Medicaid Services from CMS, the number of federal remedies, including bans on admission and federal civil monetary penalties, has decreased dramatically over the past couple of years.

State deficiencies, another measure. Having a menu of state and federal remedies helps ensure compliance with federal laws as well as compliance with many state laws in California. Unfortunately, the Department has decided that they will no longer enforce state laws pertaining to nursing homes. This is reflected...

SENATOR ALQUIST: Did you want to say that again?

MS. McGINNIS: The Department of Health Services has decided that they will no longer enforce state laws pertaining to nursing homes. I will explain; we have this on paper. We know a little bit more now than we did six months ago when we tried to figure out why the number of state deficiencies dropping so dramatically. And in fact, we had over 4,000 state deficiencies in 2003, and there are a fewer than a thousand in 2004. There's been a sharp decrease. Why is this? Well, the Department's decision to test pilot a project in the San Jose and Alameda County district offices under this pilot project, state surveyors are only examining compliance with federal laws and not with state laws.

What this illegal—and we say it's illegal because they have no legal basis for doing this—there's no legal authority for the Department of Health Services to take this arbitrary action to avoid compliance to federal laws. We're enforcing federal laws—state laws.

SENATOR ALQUIST: Do you have that in writing?

MS. McGINNIS: Yes. I'm going to read actually in a minute, and let me explain what they've done. The violations of state laws are no longer enforced in these district offices. State deficiencies, citations, and penalties are not issued. Consumers are now being denied due process. Nursing home residents are denied the hard-fought rights and protections that under state law that have been enacted by California's legislators over the last 20 years. As you well know, we've worked with Senator Mello on tons of bills and with Senator Vasconcellos, with you when you were Assemblywoman Alquist and now as a senator to get many important rights and protections for residents in California. All those have gone by the wayside as the Department has decided that they are no longer going to enforce that.

In fact, in the San Jose and Alameda district offices, complainants are even denied the right to appeal. Let me read the letter, and this is one we've been getting over the last—well, actually, since October 2004. This is in response to a complaint asking for an appeal. The only due process rights the complainants have in California is the right to appeal when they are

dissatisfied with the outcome of an investigation of a complaint. That's it. You don't have any other appeal rights under California law. So this particular person filed for an appeal:

"Dear Ms. Hanna, I am in receipt of your correspondence dated February 22, 2005, requesting the San Jose district office, California Department of Health Services, to consider your letter as an appeal to December 30, 2004, complaint investigation findings. Your request is denied. At this time, this office is following the federal complaint investigation procedure which does not include an appeals process. The Licensing and Certification Division will develop a policy regarding..."

SENATOR ALQUIST: This is in America, right?

MS. M^{c}GINNIS: Anyway, I've attached a copy of this because it's just one example of hundreds, thousands that have been sent out in response to claims in California and that I think illustrate some of the problems that we've had with the enforcement system in California, particularly over the past couple of years.

Now I want to talk about California's Complaint Response System because this is very key of SB 526, too, of why we think that dedicated Complaint Response Units are particularly relevant. Perhaps nowhere is the failure of enforcement reflected more than...

SENATOR ALQUIST: I want to mention too, the reason I'm giving Ms. M^{c}Ginnis a little more time here is that she's only on the agenda once, and we do have Ms. Capell twice, and we do have representatives from the California Association of Health Facilities twice. So I'm, therefore, giving you a few more minutes.

MS. M^{c}GINNIS: Thank you and I won't be much longer.

But under California law, the Department's required to make an onsite discussion or investigation within ten working days of receipt of a complaint. When a complaint involves eminent danger of death or serious bodily harm, the investigation must be within 24 hours of receipt of this complaint. The Department is required under law to notify the complainant within two

working days of receipt of the complaint of the name of the inspector. The Department is required to notify the complainant promptly of the right to accompany the inspector on the investigation. The complainant has a right to appeal as the results of the complaint, both in the county where the complaint was filed; and then if they're still not satisfied with that, with the way that the complaint was investigated and the result, then they can file with the deputy director's level, to Licensing and Certification.

In 2004, nearly 14,000 complaints were filed against nursing homes in California. As a result of the Department's failures, thousands of complainants had not received timely notice of the status of their complaint, few receive notice of their right to accompany the surveyor, and the majority of complaint investigations were delayed well beyond the 24-hour or ten-day timeline. As a result, 75 percent of the complaints were found to be unsubstantiated. Now think about that. This is just in the last couple of years. We've gone down to 41 percent unsubstantiated to 25 percent.

Seventy-five percent of the complaints, 14,000 complaints were found to be unsubstantiated, not because they didn't happen; but because, by the time the surveyors get out there, the evidence is missing, the staff is gone, witnesses are unavailable, and even the resident is sometimes deceased by the time the Department completes its investigation. (Coughing) You'll have to excuse me. I'm so sorry. I might have to come back and finish up in a minute. I apologize. This has been a tough morning; I've got to tell you.

SENATOR ALQUIST: Would you like to come back?

MS. McGINNIS: No. I can do it now. I apologize.

If the Department of Health Services is not issuing citations or collecting the fines, not issuing serious deficiencies or imposing federal remedies, not monitoring compliance with state laws, or not responding to or investigating complaints on a timely basis, then we have, in essence, no enforcement system in California.

The concept of dedicated Complaint Response Units as proposed by SB 526 in the district Licensing and Certification offices is not a new one. It has been recommended by our organization in annual reports since 1990. And in 1994, critical review of Licensing and Certification, California State Auditor recommended Complaint Response Teams in each district office.

The district office staff is already charged with the obligation to investigate complaints in a timely manner. Staffing complaint teams to fit the complaint workload and training the staff to perform adequate investigations will benefit everyone in the long run.

California's Department of Health Services' Licensing and Certification branch is the only consumer protection agency in California. When they fail in their job, they fail the residents of nursing homes in California. They fail people like Robert Goldsborough. They fail all of the folks that we do this work for in California. And the fact that they aren't here today to talk about what they plan to do to beef up this system, to protect the residents of nursing homes in California, is, I think, unconscionable. Thank you. (Applause)

SENATOR ALQUIST: It is noted by me that the chief of the Department of L&C is not here with us today and that there was only written testimony. It was noted by me, and I'm sure it is noted by you.

Okay. Mark Reagan, California Association of Health Facilities, who will speak to the industry view of current enforcement practices and the challenges it poses for compliance efforts. Welcome.

MR. MARK REAGAN: Thank you very much. Appreciate the time to be able to testify.

I wanted to start first with talking about when the term *"complaint"* is used to put a big word *"tale"* on it because it's important to understand how and why, what we call complaints, has changed over the past couple of years and then talk about what we've seen in terms of trend lines. When we talk about complaints, we're just not talking about the very many avenues that consumers have, either through the Long-Term Care Ombudsman's Office

through the Department of Health Services, to raise issues that they have with the care that they receive. We're also talking about facility requirements and individual caregiver requirements to make self-reports under certain circumstances. And one of the things, that if you look over the last few years—and this is particularly important when you talk about the rate of substantiated complaints—that you see the rate of substantiated complaints go down as there has been far more emphasis on facility and caregiver self-reporting.

So, for example, where beginning in approximately 2002, where there was an increased emphasis, largely from the Office of the Attorney General, to make sure that facilities and caregivers understood their responsibilities to report issues that were brought to their attention in some way, shape, or form, we had an increase of complaints that we really hadn't seen before—and so if you were to—and not surprisingly—because there is not a great deal of clarity, if at all, about when the facility must report or the caregiver must report the rates of substantiation of the facility and the caregiver self-reports already for lower rates.

SENATOR ALQUIST: Did you say there is clarity about the reporting...

MR. REAGAN: Yes. With respect to facility and caregiver reporting, the standards, or at least what's written in the law, is that the caregiver of the facility is to report either what is alleged or is suspected to be abuse or neglect in some fashion. But the Department of Health Services has never issued regulations, though they said that they would, approximately two and a half or more years ago, clarifying for the caregiver and for the facility what it means.

For example, if you have a patient with a high level of dementia report to you that there is something that you know is impossible to have happened, such as a 60-foot giant in their room, that necessarily still produces a report that we call a complaint. When we look at rates of substantiation, the rates of substantiation of consumer complaints, those

that are made by the patient and by the resident, by their family, are, in fact, substantiated at the same rate approximately that we have seen in the past. So what we have really seen is this significant self-reporting increase and those particular complaints as their styled not producing allegations that are in fact substantiated.

SENATOR ALQUIST: How does that fit with what we just heard from Ms. M[c]Ginnis? I'm really puzzled. I don't understand because what I'm hearing—she read something in writing that, for example, San Jose and the Alameda offices, that they're basically not taking, that there's no appeal process on complaint.

MR. REAGAN: I see that as a different issue. What I was speaking to was when she talked about the issue of the percentage of complaints that were substantiated. It's because how you count complaints has increased by virtue of facility reports.

Now I saw what Ms. M[c]Ginnis referred to, and she is correct that there is a pilot process out there in a number of counties where the Department of Health Services has decided, for whatever reason, to use the complaint investigation and enforcement remedies that it is required to comply with by virtue of federal law and not apply apparently that provision of state law that allows the complainant—this is the consumer, that if they don't like the results of the complaint, i.e., that it wasn't substantiated, that under state law, they do have that right of appeal. So it would seem to me that there is nothing—and I personally would disagree with Mr. Quintaro's conclusion because, even if a complaint investigation is being done using the federal enforcement process, there's not a reason why the complainant should not have the right to appeal that under state law. So I don't understand that particular clarification of Mr. Quintaro.

SENATOR ALQUIST: Well, I would love to hear from the DHS director because it sounds to me like DHS is breaking state law and not allowing by not having a complaint appeals process.

MR. REAGAN: Let me try to put some additional meat on what I wanted to talk about with respect to the number of complaints. We've heard the number of 11,000, of 14,000 complaints. As has been stated here, we're talking about 1,200 to 1,400 facilities. More than half of those complaints, as the Department's statistics would show, were self-reports. So basically what we're talking about is we're talking about eight to ten complaints completely per facility, per year, half of those, less than half of those, from consumers. And then those that are made by the consumer, they are substantiated in about the same rates that we saw prior to the self-reporting system.

SENATOR ALQUIST: When you say only about half are made by the consumer, when I hear the word *"complaint,"* I really want to say this is a human being who's having a real problem in a nursing home.

MR. REAGAN: I completely agree. And what I'm trying to distinguish...

SENATOR ALQUIST: It's a real person. It's just not just a piece of paper. It's a real human not being turned over or not given water, or what have you. So where I want to go with this is that half of these complaints are coming from the nursing home residents. On the other half, who are they coming from and what are they about?

MR. REAGAN: The rest of them come from...

SENATOR ALQUIST: The other half.

MR. REAGAN: ...the caregiver and facility reporting requirements that the DHS has never done regulations clarifying their requirements. And as a result, with uncertainty about when something actually rises to the level of suspected or alleged neglect or abuse, there is an over-reporting of those issues by the caregiver because, if they don't, then they face criminal sanctions from Mr. Robison's office which has been very aggressive in that regard. So we can have a clearer process with respect to the actual number of complaints by having more focus and clarity on the portion of them that come from the facility themselves as compared to the patient who is the

human being. And in fact, when the human being reports, more often those are substantiated. And so looking at the statistics, we can truly see that distinction, okay?

So from the consumer standpoint, what we're really talking about is a consumer, the patient, the person who lives and is turned in the facility, is making a complaint, on average, once every three months; or every facility has one complaint from a consumer once every three months. And that is—I think when we throw numbers of 14,000 or 11,000 complaints, people have to realize we are talking half of that information coming from actual facility self-reports and then looking at what that means for 1,400 facilities.

SENATOR ALQUIST: I would say too that we really don't know exactly what percentage is coming from these homes and that that's one of the things that we really need to figure out.

MR. REAGAN: I have been looking at that parsed information over the past week.

SENATOR ALQUIST: It's very parsed.

MR. REAGAN: But we can tell from the DHS claims system the source of the report, whether it came from the consumer or the facility or caregiver. So to us, having clear policy and guidance associated with facility and caregiver self-reports, as well as to have obviously improvement in field training in terms of investigation of the complaints.

SENATOR ALQUIST: _____.

MR. REAGAN: Yes. I guess what's important for me to say as I wrap up is that I hear a lot of old statistics about lots of scathing reports. Now the system's not perfect, but staffing is more than a third higher since 1999. Turnover, as we've seen from Charlene Harrington's slides, are lower. We have seven of nine areas that the federal government looks at for quality of life, and quality of care has improved in California and is over the national average.

There are good things happening in the long-term care system. And somewhere, there has to be some recognition of that as well as we all move together to try to improve care.

SENATOR ALQUIST: Right. We need to work on this together, and certainly I appreciate that we have the nursing home facilities. But what I would say, as a good Greek grandmother, as a yiayiá, is that we're not there and it's not quite good enough yet. We have a lot to do in terms of DHS. We don't have the kind of regulations that are clear until we all know what the numbers really mean and who's reporting and what all the figures mean. And it's more than that, how it affects real human beings in these institutions, whether it would be my father who was in a nursing home for a period of time in Missouri or a relative of yours anyone else who is here. You know, we want to know that all our nursing homes provide adequate quality of care and that a complainant is a human being.

And in terms of staffing, it has improved. And I know because, when I was in the Assembly, we worked hard to change some of the ratios, so we had to work so hard to do that. And I do believe many nursing homes do a great job, but I'm just saying it's not anywhere close to 100 percent. Maybe it's 30 percent; maybe it's 60 percent. I don't know that we really know. And what I'm saying is, we need to have the kind of accountability and have that information open to the public. I'm hearing kind of a recurring theme in terms of different people and different groups wanting to do a good job. I don't question that. I just think that the regulations from DHS are such that we really don't know what's going on and that information needs to be easily accessible to all of us—to the little old ladies, to the little old man who has to think about putting a loved one in a facility or has to into one for herself or himself. This needs to be a common language that we can all understand, and that's why we're here today.

MR. REAGAN: Thank you.

SENATOR ALQUIST: I appreciate what you do. Thank you.

Okay. Next we have Ms. Capell who is going to, this time, speak to contemporary enforcement challenges facing the state, the industry, and its effect on employment.

MS. CAPELL: Thank you, Senator Alquist, for the opportunity to speak again on this important issue. I want to begin by thanking you for acknowledging the work that our workers do and to acknowledge that we have a number of them who have joined us today and that we appreciate, you know, that it's important. We think it's always important to have the people who do the work represented in these conversations.

SENATOR ALQUIST: Well, I really appreciate what they do. Thank you very much. (Applause)

MS. CAPELL: I'm going to speak on behalf, and I also want to acknowledge, that by improving wages and staffing, we firmly believe it improves quality of care. And you've spent time with our workers and you know how much that is true.

I'm going to now speak on behalf of another group of workers that we represent—the nurses who do the inspections and licensing surveys on behalf of the State of California—because SEIU also represents those nurses through Local 1000 and also through Local 660 in Los Angeles County, and that I, in my role as a representatives of nurses, have been meeting with them and talking with them.

I want to point you to one of your very helpful charts on staffing and total hours of inspection for skilled nursing facilities and look at the total number of field evaluator positions filled between '99-2000 is 467; 2000-2001 goes up to 557. And then in '03-'04 is at 443 and we believe has continued to drop. And I want to tell you from our nurse's perspective what the reality of that is in terms of doing enforcement, in terms of doing inspections, in terms of responding to complaints. Where they report to us—and these are the working nurses, not the people who do the budgets or manage all of this—they report to us that where the field offices used to have 25 to 27 full-time equivalents for surveys and for enforcement, there

are now 16 to 18, and this seems to be quite consistent about the field offices. Where they used to have three or four staff for every survey, they now have one or two, and they have the same number of nursing home student staff in the same amount of time. So literally, they are doing the same number of surveys every year with half as many staff. I'm shocked by what that means in terms of enforcement.

In terms of complaint responses, the reports we have from our nurses vary. They try very hard to meet the deadlines for the ones that are urgent, and they think they do a pretty good job of that, although never as good a job as Ms. McGinnis would want or they would want to do if they have the staff to respond.

In terms of non-urgent complaints, some field offices in the nurses' field, is they're reporting on these reasonably timely, in others, that's not true. They have long, they reported long backlogs. And it seems to be, as we pick up the reports from our working nurses, uneven. What is consistent—and this seems to be true no matter, in what way they're dealing with nursing homes, what is consistent is the turnover is high and morale is low because the working conditions are bad; the wages are inadequate. And that's as true for the nurses who inspect and surveyed these facilities as it is for the workers who work in them. It was exactly the same story again.

And as I've gone back and tried to track individual nurse health facility—they're called HFENs, Health Facility Evaluator Nurses, the turnover is really quite astonishing. And this is not, I would say, characteristic of nursing. As you know, I represented nurses now since 1986, almost 20 years. Many nurses have stable careers, stay in the, literally, the same shift at the same hospital for years and years and years. To have this kind of turmoil in state service, which is more usually characterized by stability, is a sign to us of a really troubled area and something that we're very committed to try to fix on behalf of the residents of the nursing homes and of the nurses who—these nurses went into this in order to improve quality of care in nursing homes. They're dismayed by what they find, the reality of it.

They report as well that they are disheartened that in the last few years there has been more intensive scrutiny of the complaints that they—that when they write up complaints, that when they write up licensing surveys—and I haven't gotten all the technical terms perfect, and I apologize for that, but when they would write them up, when they write up a nursing home, that they more often have their work rewritten, re-reviewed, rechecked and that where it used to be that a nurse evaluator could simply write up a citation, talk to her manager about it, and they were done, now there are multiple levels of review someplace else, that they don't have any way of reaching or understanding. And their recommendations are, from their perspective, too often changed.

SENATOR ALQUIST: So are there recommendations filtered?

MS. CAPELL: We're in the process of evaluating exactly what's transpiring and attempting to, in the interest of our nurses, who, after all, are licensed as registered nurses and are putting their license on the line every time they sign a survey of evaluating the options that are available.

We recognize that this is merely information in this conversation, and it's something that we bring to you in an attempt to pursue as we move forward about the context of our collective bargaining relationship with the Schwarzenegger administration which has been resistant to providing adequate wages or adequate staffing in these areas and also within the policy arena as we move forward in next year's budget process. But we would say to you, the reality on the ground is pretty bad from our nurses' perspective, and so we look forward to working with you and the Budget Subcommittees on these issues as we move forward.

Thank you.

SENATOR ALQUIST: Thank you very much.

Next we have Linda Robinson, Long-Term Care Ombudsman Coordinator from Santa Cruz County, who will speak to the description of current concerns about the complaint investigation system from the perspective of a local ombudsman coordinator, the effects of the current

system, the effects the current system has on the way the long-term care ombudsman carries out its mandates and role. Welcome.

MS. LINDA ROBINSON: Thank you very much, and thanks for letting me speak today about these issues.

My name is Linda Robinson. I'm the coordinator for Santa Cruz and San Benito County Long-Term Care Ombudsmen Program. Can you hear me okay?

SENATOR ALQUIST: I can't. Can you hear in the back? Bring the mike a little closer and speak a little louder.

MS. ROBINSON: I'm the coordinator—is that better?—of Santa Cruz and San Benito County Ombudsman Program. I've been an ombudsman for eight years, and I work for Ombudsman/Advocate, Incorporated. It's a nonprofit agency that has the Ombudsman Program and Patient Rights Advocate Program.

The statements I'm going to make today represent the experiences of our program, Santa Cruz/San Benito County Ombudsman Program only. The Long-Term Care Ombudsman Program is federally and state mandated. We advocate for residents living in skilled nursing and residential care facilities. We receive and investigate and resolve complaints on their behalf. We identify systemic problems. We maintain an active presence in the facilities. We work to protect the rights of the residents and to ensure they have the highest quality of life and care possible. Ombudsman acts as a voice for residents, which is why I'm here today. There are many residents and family members who are unable to come to this hearing today. I and several others of us are here to speak on their behalf, if they get a chance. I think it would also be nice to hear more consumers if the opportunity presents itself.

Ombudsmen do not have enforcement capabilities. We rely on the Department of Health Services' Licensing and Certification to enforce the regulations and find sanctions to enforce compliance. As an ombudsman in Santa Cruz and San Benito County, we see what works, I see what works

and doesn't work on a daily basis and we're in a prime position to identify the gaps in the system.

Some of the problems we have identified with the licensing investigative process are: timeliness, thoroughness, and effectiveness. Unsubstantiated complaints or no sanctions lead to repeated violations. Residents are continually at risk, the quality of their lives and their care is threatened. It's frustrating for ombudsmen when they report residents' rights violations, and they're repeatedly unsubstantiated by Licensing. For example, we had an active case in our county. I was told by the licensing evaluator that maggots are sometimes used in care treatment. Please keep in mind while I'm speaking that every complaint involves a person, like you said earlier, who's affected in some way. Their quality of life is affected, their care is compromised, and they're very vulnerable.

There were a couple of presenters here talking about numbers of complaints, and you've heard a lot of numbers thrown around.

SENATOR ALQUIST: Would you comment on that, please.

MS. ROBINSON: Yes. My comment is, those are complaints that have been reported to the Department of Health Services. Ombudsman—I wish I had the numbers of how many thousands of complaints ombudsmen around the state address, receive and investigate, that we don't report because we've resolved them at the local level, at the facility level. So again...

SENATOR ALQUIST: How do you resolve them at the local level?

MS. ROBINSON: We resolved them by working with the staff, you know, taking the resident's complaint to the staff for resolution, possibly to other agencies.

SENATOR ALQUIST: So many times, it is resolved at the local level?

MS. ROBINSON: Many times it is.

SENATOR ALQUIST: That's good.

MS. ROBINSON: And often it's a communication problem that we just need to clarify some things.

The other thing, I want to make one more comment really quick about the complaints is the speaker from—covering health facilities—talked about the increased number of complaints that are coming from staff and facilities.

SENATOR ALQUIST: I have questions about that.

MS. ROBINSON: The answer to that is that's because that's the state law, the Welfare and Institutions Code that says "*...facility staff are all mandated reporters of elder abuse...*" and you have adult abuse. So they're required by state law to report any allegation, any suspicion of abuse occurring in their facilities. That's what those reports are about.

SENATOR ALQUIST: I do a lot in the elder abuse area. So what happens if staff reports a problem with elder abuse to DHS, to Licensing and Care? I mean one thing I'm hearing is that there isn't a follow up now? Would you like to comment on that?

MS. ROBINSON: Well, yes. If the case is severe, which they're only investigating the most severe cases right now, call them Priority 1, so that he has been injured or there's a threat, an immediate threat to their lives or in danger, they will come out and investigate it, you know, soon. But any other complaints are held for weeks or months, and it could be resident-to-resident altercations. There could be abuse where there haven't been any injuries.

SENATOR ALQUIST: So would you give an example of that abuse where there hasn't been an injury and it's taking a long time for DHS or L&C to come out? What kind of situation would that be? Would you explain it to us?

MS. ROBINSON: It would be something like maybe a resident was—well, we had a resident who had been pushed out of his bed by a staff person and he fell and hit the trash can and said that he had some injuries. Well, it took a really long time for them to come out to investigate. I'm thinking close to, about three weeks. But by then, that person's injury has been healed. But the ombudsman was there—we were there. We were there the day we got the report. We cross-report with Licensing as part of

our mandate. But we were there. I ensured I was the one who worked on the case and ensured that the guy got medical attention. In a lot of cases, this is what is happening, is Licensing may not be out there in a timely manner, but the ombudsmen are out there. And we are resolving to try to get these complaints resolved.

It's the times when the complaints aren't being resolved, and the systemic problems in these facilities go on and on, that we really need Licensing to step in and start inputting some enforcement to these facilities so that they will start complying. That's a little bit about the complaint process, but I'd like to talk more about how it affects how we do our work and how it affects the residents.

A lot of times, also, when these complaints aren't investigated in a timely manner, the facilities aren't cited. We're finding they're not being cited. The evidence is gone, you know, some things that Pat spoke about. You have residents who forget about particulars of the incident. If it's weeks or months later, they're going to forget what time it occurred, who was involved. And when an evaluator may ask him what happened and they give a different story than they gave the facility administrator, then they'll say, well, you know, their report is really not—they're not giving the same report each time and so we can't substantiate it. Or often, when the complaints have already been resolved, they're not substantiated. So they may have been resolved for one person, but it's probably affecting a number of other people in that facility. When it's unsubstantiated, then there's nothing there to hold the facilities accountable for correcting their actions.

Residents have told Ombudsmen that nobody believes them when their complaints aren't substantiated. And so even after they told the staff, the ombudsman, and Licensing about their complaints, when they weren't investigated in a timely manner, these residents feel dismissed. And I ask, is this the quality that we value? Is this the message that we want to send to residents? Like, what was the intent of the law? An Act to ensure the safety of the residents.

Just to let you know, for most residents, it's really a big step for them to file a complaint. They're afraid of retaliation. Residents have told me that they were treated differently by staff or that their call light wasn't answered after they filed their complaint. Some of them are afraid to file a complaint; they're afraid to let the ombudsman know about their complaint. So when they do file one, they're taking a big risk. They have a lot of fear, and I just wonder if fear is the kind of thing that we accept, it is acceptable to us, what we would want for our family members and people we care about.

One family member waited till the death of his wife to file a complaint after he had tried to settle his complaint with the facility staff. He filed it with the Department of Health Services after his wife died. He waited three months for that complaint to be investigated. And his complaint had to do with care issues, medication issues, and responding to his wife's call light in time. And he keeps calling and saying, *"When are they going to investigate my complaint?"* And I say to him, *"I'll check. I'll let you know."* And, really, what he wants is some closure. He wants to hear from them.

When I told him I was coming today, he wanted me to tell you that, he said, "I want to see it changed. People don't know what they're getting into, and I wouldn't have put my wife into a nursing home that does those things."

We hear so many stories from residents about abuse and disrespect and violations, all kinds of problems. We do a thorough investigation. When we do forward it to Licensing, we hope for and we expect some action. But how do we as applicants go to these residents and say, *"I don't believe your complaint is going to be investigated by Licensing?"*

SENATOR ALQUIST: It sounds like you don't have any power to make the change.

MS. ROBINSON: We don't. I mean we work so hard at it. A couple of our nursing homes that have about a third of our complaints come from two nursing homes. We're in there three to four times a week, and we work really hard at trying to address the systemic problems that are occurring.

We say, *"Look, try this, try that."* We do a lot of follow-up with them. Those are times when we really need Licensing to step in. And when they're unable to address and enforce change of the systemic problem, then we see the system is broken and the system really needs to be looked at.

SENATOR ALQUIST: Well, I'm most disappointed that Licensing from DHS did not show up. Everyone else did, and I appreciate everyone who did show up. It's very obvious that they did not; they should have been here to hear us and to answer some of these questions and to tell us how they're going to fix some of these things.

MS. ROBINSON: Certainly, it would have been nice. Do I have time to give you more examples?

SENATOR ALQUIST: One minute because we're _____.

MS. ROBINSON: Just to give you an idea of some things that weren't substantiated, physical abuse to residents by staff persons, Licensing didn't substantiate that it was abuse. That person kept working there. The facility staff told me that they rely on Licensing's findings to decide whether or not to fire employees. That person kept working. And just last week, I got two more reports of physical abuse by that same staff person. Now that is not helping residents feel safe. That's another problem. We had a number of resident abuses within a facility.

SENATOR ALQUIST: I know we have some good nursing homes, but I also need to say no resident in a nursing home should have to fear for her or his life...

MS. ROBINSON: No. They shouldn't, they shouldn't. And before the time where we need Licensing to step in, you asked me for an example of what they do with abuse responding, resident-to-resident altercations. It occurs all the time. They're not going to come in right away. We had a resident who had pushed a couple of residents or hit them, and Licensing is not going to come in and do much about that in a timely manner. But what happened at this one nursing home, on the third occasion, this resident pushed someone who broke a hip and died from complications. So you have

the regulatory agency not stepping in and telling the facility that you need to protect your residents from this one resident. And then we have a facility not self-correcting their problems, not taking the initiative to keep their residents safe, and those two things combined led to a really tragic end for this one resident.

I'd like to talk a minute about the pilot project because our county has been affected by that pilot project, which I discovered back in October—I'm not very sure when it started.

What we found, the problems with the pilot project, is...

SENATOR ALQUIST: If you could please explain the pilot project for everyone.

MS. ROBINSON: Oh, the pilot project is....

SENATOR ALQUIST: We have a little more time.

MS. ROBINSON: Okay. So the Department of Health Services' Licensing and Certification—I think back in September or October it started, but a pilot project in the state of California in four—I think it's affecting at least four counties. But it's the San Jose and Alameda district office; our counties—Santa Cruz and San Benito—are under that office. So when they look at complaints that we file or anyone files, instead of looking at California law, they're looking at the federal regulatory system. They're looking at federal laws. So in a sense, they're really disregarding California law. And in that law, we have the elder, dependent adult abuse, where facilities have to file abuse and there's a fine if you don't. We also have the staffing ratio law in California law. So you've got a couple that are disregarded as well as a lot of residents' rights that may be stronger in state law.

The other thing that's happening is there's no citations being issued. But these citations, you get some financial incentive for nursing facilities to correct the problems. So that's not happening. The appeal rights were a big thing. Pat talked about that. We filed two appeals on behalf of residents in our county, and we were told, *"You no longer have appeal rights. We deny it."* And I thought, well, how in the world can they deny somebody's right to

due process? So those folks were not able to appeal. And anyone else in these counties lost that appeal right from October 2004 until I was recently told by the district office, that as of June 1, the appeal rights were reinstated. Now I'm not sure if...

SENATOR ALQUIST: Are they reinstated?

MS. ROBINSON: I don't know. I was told that. I haven't seen anything in writing.

SENATOR ALQUIST: Is it something we need to look into?

MS. ROBINSON: It would be something to look into. So having been in one of these programs affected by this pilot project or part of this pilot project, I would like to say that it may be abandoned right now, in this current form, it needs to be re-looked at because I was told also that it's going to roll out statewide or it may roll out statewide. Now these problems really need to be looked at before it does go out statewide. All laws, regardless of their origin, should be utilized in ensuring compliance.

I'd like to say that we support your bill. We think that it's wonderful to look at straightening residents' rights and establishing the Dedicated Response Unit within the district office. Hopefully, it will result in more timely investigation. There's always going to be a need for skilled nursing facilities, but the system that's currently in place to regulate and evaluate the care level needs to be re-examined and re-evaluated to see if it's meeting the needs and that it is guaranteeing a quality level of care. We need to question whether the minimum standards need to be raised. We're all aware of the budget cuts and the constraints that Licensing has been operating under. We, too, have had a lot of cuts, but the mandate of the minimum standards that are established under law that were motivated by need, need to be upheld, and that means doesn't exist today.

SENATOR ALQUIST: I wanted to thank you so much.

MS. ROBINSON: You're welcome.

SENATOR ALQUIST: While you are up there, I wanted to mention _____ checking with my consultants who helped me on my legislation. On

residential care facilities, now it's once every five years for them to come in and inspect? I had a bill this year to change that from once every five years, announced, to once every other year, unannounced. It got held in committee, but I do promise you to carry that again because the analogy kind of is, I can clean my house once every five years, but you don't know how it's going to look the other 364 days. So I think it should be common sense to say that every single day the facility—and as I said several times, there are some that are very, very good. But like anything in life, we need to keep looking at the ones who are not doing a good job. And, certainly that includes DHS's role in this, which I think is major in terms of what they are not providing.

And in terms of this pilot project, when you said the pilot project _____ stay at the state level, I wasn't going to say it out loud, but I will say it, you know, *"Over my dead body."* (Laughter) But I also know that this is a process and it's simple majority, so maybe it would be over my dead body. (Laughter) There's so many things that we'll be working on.

And I want to thank you for your courage in coming forward and sharing all of this with us because the goal is not to hear some of these very sad stories just to make them feel bad. The goal is to hear what's going on. I basically believe people want to do good in life. I guess that's what you call an *"optimist,"* and I think we need to have the kind of structure and infrastructure that puts out what our expectations really are, state what the expectations are, and then have a process to see that we follow that because certainly, in a person's elder years, it should be a time—one of my neighbors—I have several elderly neighbors, and one of them came up to me recently and said, *"You know, Elaine. It's not the golden years; it's the rusted years."* Right across the street and one over in Santa Clara. And I'm thinking certainly, whether people are in their own homes or whether they're in facilities, they should not live in fear. We should not live in fear. And I believe that if we talk about this, then we can come up with ways for changing laws. So thank you very much.

MS. ROBINSON: You're welcome. (Applause)

SENATOR ALQUIST: We have four people now who will speak under this section called "Consumer Sounding Board," and they wish to come up—Julie Fudge, Patricia Bryant, Suzanne Swift, and Kathleen Johnson. And this is an informal opportunity for consumers to provide input and insight to testimony that was provided. And if you would each like to take a minute or two, we would really appreciate that. We'll start with Julie, Julie Fudge.

MS. JULIE FUDGE: Thank you. I'm not quite sure I can get it done in one or two minutes, but I'll do my very best _____, and I want to thank you for your caring and for your talking about fear. So many of the residents don't make complaints formally with DHS because they are afraid. Shall I get a little closer? Okay. Is that better?

I was my mother's primary caregiver for almost six years while she was in a skilled nursing facility in this area, which I will not name, not to protect the facility but show that the problems are widespread.

Since I usually spent 20 or more hours a week in this facility, I saw and heard many things which alarmed and dismayed me. However, the brief time I have available to me, I will limit my comments to these areas, the amount of time it took for my problem and complaint to be investigated, the quality and nature of the complaint process, and how those might be improved to be effective and just. When I learned that the state survey of the facility was ending on May 14, 2004, the ombudsman and I met with a team, including a preceptor in training from San Diego, to share the egregiously neglectful care which hastened my mother's death when the facility and an LVN did not monitor my mother's oxygen level when it dropped to 66 percent, which is about 30 percent below what it should be.

One of the team, who I knew from previous surveys and who had refused to meet with family members of previous years, tried to placate me. But the preceptor in training wanted to hear my story. I shared the essence of it, and she was so upset, that she called the Licensing administrator at

DHS from the airport to urge this case to be investigated, even before I filed a complaint.

On May 17, 2004, I filed a written complaint with State Licensing giving many details. On May 19 I received my letter with them which officially started the complaint process. The letter stated that L&C must certify the violation through direct observation, interviews, or review of documented report and, *"Once the investigation is complete, you'll be notified of the findings."*

Soon, I requested an investigator, other than the one on the survey team, and the one assigned said she was so far behind, she was working on a 1999 complaint. Four and a half months passed with no word of an investigation being conducted. So I called the ombudsman who suggested I might want to call CAHNR. I learned that California Health and Safety Code states that *"an onsite inspection must be done within 10 days of receipt of a complaint."* I just learned today, however, that I should have been able to go there with the investigator, and I didn't know that until I learned it in this hearing.

On September 28, 2004, I sent a letter to the district administrator in Daly City advising her of this and urging her to comply. I never received a response to my letter.

On October 25, I called the ombudsman for advice, and she told me that the director of nursing of the facility had told her that the investigator had been there.

SENATOR ALQUIST: Always do a cc to your state legislator.

MS. FUDGE: You know, I had done that _____, I'll talk more about that later _____. But you're not my representative.

SENATOR ALQUIST: I meant from the point of view, too, of getting people to respond to you since you were also...

MS. FUDGE: I've had difficulty getting them to respond, too. In November, when I talked to the investigator, I told her that I had copies of the charts from the time in question in case she wanted to compare them to

the ones she was shown. She did not. She said she was typing the report, but she had no idea when I would receive it, because it had to go to her supervisor for his signature first.

On February 3, the investigator called and said the LVN denied everything I had reported, and that she "gave her every opportunity to come clean," but she didn't. The LVN told her that she had taken my mother's oxygen saturation level earlier but hadn't charted it. The ombudsman told me that the rule is, if they didn't chart it, it didn't happen. Yet the investigator said that since it was just the LVN's word against mine...

SENATOR ALQUIST: It's been four minutes. If you can close, please.

MS. FUDGE: She said that you have to have an independent, competent witness to substantiate a complaint, and on that basis, because there are generally in a nursing home no independent, competent witnesses. They're either staff or they're people that you know, or there are residents who are not competent to testify.

So 10 months after the complaint on March 21, the complaint—I got *"the complaint could not be substantiated"* with no information about what had been found and no written record of the information the investigator had shared with me on the phone.

Since facilities do not want to receive citations and possible finds, it is not in their interest to urge staff to tell the truth. It is not in the staff's self-interest to be honest when they've made a mistake because it could result in losing their job and their license. And since the rules are such that most complaints can't be substantiated without their cooperation, it's a wonder that citations are issued at all. But when citations do carry a fine, the record shows that rarely are they ever collected. Obviously.

SENATOR ALQUIST: Thank you. Thank you very much.

MS. FUDGE: Thank you.

SENATOR ALQUIST: What I'm trying to do, so you all understand it, is, just talk to us and tell us what occurred, but I want to be able to have all of

you have enough time to speak because then after that, I'd like to be able to take time for public testimony for anyone who wishes to speak. Knowing we will not be able to do everyone. And with everything, we still need to be done by 12:30, so we can try and do it that way. That's the only reason I keep saying—there are so many good witnesses that I want everybody to have a chance to speak. So, thank you very much.

MS. FUDGE: You are welcome.

SENATOR ALQUIST: Okay. Patricia Bryant.

MS. PATRICIA BRYANT: Hello. Thank you. I appreciate this opportunity. I'm going to try and very briefly outline my complaint process. A skilled nursing facility in Los Gatos. My mother is 85 years old—was 85 years old. She had advanced dementia. She was wheel-chair bound, but she has no physical health illness whatever. She's healthier than me and you.

What happened—I was her conservator. I've always hired someone to spend about—because chronically understaffed, things weren't—she was not getting the one-to-one attention ____ gets, okay? So I've always hired for about two to three hours a day for four-and-a-half years, she was in a nursing facility, I've hired people, as my mom's conservator, to spend this time with her. In addition, I was spending anywhere from one to three hours a day with my mother. I was all over the place. I know everything that goes on in a nursing home and worse.

What happened is in March 2004, they changed charge nurses, what they call LVNs. Unbeknownst to me, my mother's Kaiser, Dr. Chin—she visits the facility—it's her designated facility to take care of. Unbeknownst to us, this charge nurse outwardly falsified my mother's medical record. She would write—she was not following the prescriptions. If she chose to, she would do anywhere from three to 15 hours after they were supposed to be administered and back into medical records. All this came to a head when my mother was in the process of dying in this facility. So all this period of time, she was falsifying the records. And this led to, she got overdosed on

her psychotropics, she had a stroke, she lost her ability to speak, and she was partially paralyzed. So she declined in six months under this one nurse's care.

In addition to that, she was abusing the laxatives, and my mother got the infamous *"toxic wound."* The doctor came out on three separate occasions during this period of time to train and specifically give a very direct order how to treat this wound and to heal it. The nurse absolutely refused to follow the doctor's orders.

This went on. And then finally Labor Day 2004 came up, and everybody was gone. This nurse was in charge of the whole facility. My mother was put on a catheter as one last-ditch effort to get this woman to heal because we're talking grafting flesh, which is what happens a lot at nursing homes. Wound care is rampant. These nurses do not have the education, time, or the concern to treat wounds, period. My mother is out, so they put her on a catheter. Sure enough, she had—she developed within two days or so a urinary tract infection. The doctor was never notified. That led to her contracting at the facility e-coli, a very virulent strain. By the time my mother went to the emergency ward, the doctor was never notified all this period of time.

By the time my mother ended up in the emergency ward and got diagnosed and they tested for the virus or bacteria, it was too late. My mother was so damn healthy. I spent 23 hours a day for seven days a week next to her watching her die because her body was so physically healthy, and it was too late to save her with any kind of antibiotics.

So what happens here? Oh, Labor Day, this all came to a peak. This is just before my mother went into emergency. Dr. Chin comes to visit the facility because of my communications over the holiday. She comes to visit and talks to the director of nursing. That director of nursing is fired. I come in again and talk to the facility administrator. He resigns. All of this is in anticipation of what's going to happen when I file my complaint to DHS and with CANHR and the ombudsman, I filed my complaint. This was in the

middle of September my mother died. I filed my complaint on October 11. I got—on November 3 DHS finally sent me a letter acknowledging it and assigning a number. I spoke to their supervisor. She said that my case was a very low priority.

You would not believe the documentation. I have very detailed, factual, historical documentation. I have the support of my doctor who will come and testify. So DHS told me my case is low priority; they'll get around to it. So finally, at the very end of December, the investigating RN goes out to the facility. I repeatedly asked her to speak with me, to look at the evidence that I have of all these, you know prescription failures and treatments and everything else that defines this nurse. Did not do that. She went ahead, went by the book, and just did all this, whatever. She spent 15 minutes on a phone call with Dr. Chin, okay? That was Dr. Chin corroborating my story.

Then in April, the DHS gives me their findings. They find the lowest level deficiency, something or other, a Level D, basically a slap on the wrist. Then back in May, I, obviously, again with CANHR's support, I asked to have an appeal hearing. I got a letter from Quintero stating that they were going to decline, okay? At this point in time, that charge nurse is still at the facility. I'm working with DHS, the Licensing Board, one other agency—it slipped my mind right now. I'm personally targeting this nurse, and she wants to open up a care facility under her license in Santa Cruz County and/or Los Gatos. So I'm after her.

I was hoping that this DHS complaint finding would help to get this nurse out of play and not to open up more facilities under her license. And right now, I have an assigned officer from the Hayward office, so I'm doing everything I can. It's kind of like sit back and wait; we're not obligated to give you any information, whatever. I'm very vigilant. You can tell I'm very adamant, very organized. I have a lot of documentation. I have a lot of support. Nothing came of this. My mother's dead.

SENATOR ALQUIST: Thank you. I'm so sorry for her.

MS. BRYANT: So am I.

SENATOR ALQUIST: To hear all of this.

MS. BRYANT: And you know what? I'm not the only one. You saw the vigilance. Think of all the residents who don't have someone like me on the premises.

SENATOR ALQUIST: My father was put in a nursing home in Missouri, and it was in a rural area, and the doctor was just very much on contract. The doctor prescribed Haldol without even seeing my father. My father was probably 93 at the time.

MS. BRYANT: I call it *"Helldel."*

SENATOR ALQUIST: Yes, without even seeing him. And, you know, I was calling every day from California and then flying out when I could, and it had horrible effects on him which eventually, I think, had something to do with his death. And my way of dealing with it after that was to pass legislation in California that says when doctors prescribe psychotropics in nursing homes in California that within a 48-hour period, the family needed to be notified, that 95 percent of the cases were patients wanted their family to be notified. If a patient says, *"No, I don't need to be notified,"* nobody was notified. But the other 95 percent, they were notified, and that was my way of dealing with the grief and what had occurred. Thank you.

Suzanne Swift.

MS. SUZANNE SWIFT: I'm Suzanne Swift, and my mother was a resident in a nursing home, skilled nursing home, for six-and-a-half years. My experience will be brief but it takes a little bit of a different turn on the process of complaints.

My mother fell and broke her shoulder. She was admitted to a skilled nursing facility. She was in mid-stage Alzheimer's disease at the time, but totally ambulatory and no other health problems at all.

Before I placed her in this facility, she needed to attend physical therapy after she broke her shoulder. I did much of my own research. I talked to CANHR, I talked to the local ombudsman, I spoke with her doctor,

and I spoke with the Alzheimer's Association to get referrals. I finally found a facility I thought would be okay. None of these resources turned up any information of any complaints against this facility, okay?

My mother was in the facility. Within 10 days of her being in the facility, in spite of the fact that I was with her every day, four to five hours a day, she developed Stage 2 cubitus ulcers within 10 days. I immediately researched and found another home for my mother. I went down to her home, pulled her out of this facility, hired nurses for her care. And the moment that I removed her from the facility, I filed a complaint with DHS. DHS—I was luckier. They did come out a couple of years ago. They did come out. I went with them. I knew my rights; I had done my research. I went with them for the investigation. They did substantiate my complaint. They decided to give the facility a Class A citation, okay? The facility appealed it. I went to the appeal hearing. The citation upheld, okay? Two months later, the facility does it again to the State Attorney General's Office. I was not notified of this appeal. The appeal was plea bargained down to a B-class citation.

I was told when I called the district manager for DHS, he said to me, *"Well, we don't have the money or the resources to prosecute these complaints, so we couldn't send anybody to defend it. We did fine them."* However, they never collected the fine. My mother did end up in a wonderful nursing home. It's one of the 5 percent. I can guarantee that. However, my problem with this whole situation is, once they did find on the complaint, there was no clout; there was no enforcement from the agency to make this nursing home pay or even correct their action. What I found out later on through subsequent inquiries that they had many complaints against this nursing home. But I consider myself an informed consumer. I could not, and nobody else could either, find out what this nursing home and the egregious treatment it had given. There's no documentation. It has all been swept away. And that, I think, is just abominable.

SENATOR ALQUIST: Thank you.

Kathleen Johnson.

MS. KATHLEEN JOHNSON: I don't have an example, or I have many examples. But from what I've heard today, I want to spend my time responding and offering some suggestions.

I am a former certified ombudsman. I'm now the director of the agency for which Linda Robinson works. And I'm here on behalf of residents, not only in Santa Cruz and San Benito Counties, but obviously residents throughout the state. And there have been a few things that have been brought out by various presenters that I think need to be addressed. I'd like to talk about the idea of accountability within a facility, and there have been instances that have been given about the way staff provides care or doesn't provide care, the training, the staffing level. And there's one very important thing, I think, that needs to be addressed, and that is, that the quality of care and the manner in which care is given does not have to relate to the number of staff, but comes directly and is set by the administrator and the department heads at that facility. The qualifications, the testing, and the standards that need to be looked at to become an administrator and what is required of that, and who holds that person accountable needs to be addressed. That is something that every facility can do *without* increasing the cost. We know that the facilities—many of them feel that they're not getting enough profit.

The second thing is the evaluators, who I'm glad that Beth Capell spoke to this in that in her example of the evaluator, she continually referred to them as nurses. And this is another problem on the other side, and that is, that with evaluators going in working for the Department of Health Services and going into a facility that is a medical provision or a medical provider, what we have is a coalition of cultures. The question is, is the evaluator going in as a nurse, or is it her education as a nurse that should make her a better, more aware evaluator?

The licensing issue of losing a license, the idea of—and we've heard evaluators say this—we've looked at the charts, what the doctor has ordered

isn't anything that we even want to address or bring into account because we don't have any influence over the doctor's orders. And staff, when they say, *"The doctor ordered it—we were just following doctor's orders"*—they buy it. So the question is and the need is the standard of training and the accountability and consistency from evaluator to evaluator and the recognition that they are in a role of evaluator, not in a role of a practicing nurse.

SENATOR ALQUIST: How would they look at it differently then?

MS. JOHNSON: When an evaluator goes in, they have a set of regulations that they're following. In our experience and in my previous experience as an ombudsman, evaluators would say, *"Well, the doctor ordered this"* or we see it in the chart and it says, and this is what is in the chart and this is who—and it's initialed that this was done.

SENATOR ALQUIST: So, it's the process.

MS. JOHNSON: So it's actually objectivity, and it's the difference between the culture of being a nurse and that whole atmosphere that says you don't question doctor's orders, and this is what we do as nursing staff; this is what we follow. That culture, versus going in and looking at the regulations and everybody is equal and even, and the regulations are to be enforced...

SENATOR ALQUIST: Which is the process.

MS. JOHNSON: It is part of the process, yes. In addition to that, the facility, all the regulations are set up for facility operation and compliance. And as such, the regulations require that each facility have a medical director, that attending physicians be a part of the facility, that they need to have the availability of psychiatric services. All of these requirements are requirements under the regulations, but the enforcement agency, Department of Health Services, has absolutely no authority to regulate those requirements. So an attending physician is out of bounds for Department of Health Services; the medical director, out of bounds for the Department of Health Services; psychiatric providers, out of bounds for the Department of

Health Services. When there are concerns and complaints by residents about the doctor's care, about the attending physician that they don't recognize and they've been in the facility for a year, about a medical director who is the medical director for a facility and is also the attending physician for about 85 percent of the residents in that facility and there are problems with—and the residents are complaining about the physician, and the physician is in fact the medical director, so there's no way to go. There's no oversight by Department of Health Services?

SENATOR ALQUIST: How do we make it in bound?

MS. JOHNSON: What I believe is that the regulations require that these individuals or these roles be filled within a facility setting. Then anyone and everyone operating within a facility setting is under the purview of Department of Health Services. Their behavior, the manner in which they do their jobs, are within the realm of the facility. And if a facility is going to be held accountable, the administrator is going to be held accountable for deficiencies and violations, then the people who potentially are initiating those violations need to be accountable as well under the Department of Health Services.

SENATOR ALQUIST: Thank you very much.

I want to thank all of you for being here. Kathleen, we appreciate that kind of insight—it's very helpful—and to Julie and Patricia and Suzanne speaking as her daughter.

Both my parents have passed on. I really relate to what you have to say, and God bless you and _____ we all appreciate that.

MS. JOHNSON: I'd just like to say one thing, that an ombudsman told me, *"You're not protected. You're just supposed to think you're protected."* And I'm really hoping that the Senate Bill will give us some real protection. Thank you.

SENATOR ALQUIST: What we're going to do now—and I'm not quite happy where I thought we would be, but it's close enough, I guess. I'd like to take eight or nine minutes for any public comment. The way we will work

this is, if you would like to come to the table and state your name and take just a minute to share any thought you would like to share.

MR. PRESCOTT COLE: Thank you, maybe just for a moment. My name is Prescott Cole, staff attorney for CANHR, California Nursing Home Reform.

I want to just address this one issue that...

SENATOR ALQUIST: I want to say muchas gracias. I know we have AARP and also the El Centro Latino chapter of AARP, and I know people are leaving and I just want to say *"thank you"* right away. (Applause)

MR. COLE: It's a matter about understanding the reports that come in, complaints from staffing. And it's put out here that complaints have increased because the facilities _____.

There are two different statutes to understand here. One is the Welfare and Institution Code.

SENATOR ALQUIST: And you did say your name and that you're from CANHR...

MR. COLE: Prescott Cole. Again, 15630 was designed to make the mandated reporter report all abuse. But in that statute, it's a very complicated formula to really make it so the mandatory reporter doesn't really have to make a report. They don't have to make a report if it's a four-part puzzle that the individual making the report is under doctor's care, if the care plan is being properly put out there, and if the injury is a direct result of the care plan, improperly administered, and if they don't have reason to believe that there was abuse of a client.

Now the Attorney General's Office has been very aggressive over the last couple of years with training mainly for the reporters. So we would hope that the mandated reporter would get by that four-part, little puzzle they have to do to make more reports. Now when you split out here that facilities have to report abused alleged, or suspected abuse...

SENATOR ALQUIST: Excuse me. If you all could take any private conversations out into the hallway... This is still part of the hearing, and we

still would really like to hear from anyone who would like to come forward, but we'd like to be able to hear them. Thank you.

MR. COLE: And this is the last point, that facilities have second reporting requirements, second from the mandated reporter. So when it's pointed out here that all reports of the facility, it's not true, it has to be parsed out. The only way to determine if these reports are extra reports coming in from those statute, from the Health and Safety Code, which is 1488.91, it's only up to _____. You'll never know unless the Department of Health Services' Licensing and Certification tells us what part of facilities are reporting and what part of the mandated reporters who are coming in, the people who are doing the care, are they reporting? And if they are reporting and reporting under these restrictive formulas, so you can bet that those reports are really well thought out. Thank you.

SENATOR ALQUIST: Thank you, Prescott. We can talk more about that also. Thank you.

And did you just quickly want to come up and just say your name and the point you would like to make?

MS. KATHRYN MANENTO: My name is Kathryn Manento. I'm an AARP member, Milpitas Senior Advisory Commissioner, and I do health surveys—I mean national survey—for five years, and it is really an honor and privilege for me, Senator. I'm nervous because...

SENATOR ALQUIST: Don't be.

MS. MANENTO: ...to actually see someone who's actually listening and caring, just makes me want to cry.

I'm very concerned about the balanced budget for California and that every Californian has the right to live with respect and decency. I'm concerned for the growing losses in nursing homes. And as the last lady spoke, we're saying nursing, but it is the whole gander—administration, doctors—and she also left out X-rays.

I had family members that were taken far better care at home and died in nursing homes. _____.com on the internet is such a horror story. My

own situation is so frightening, that after my thyroid was removed and I was in Superior Court without a lawyer against Amtrak, the judge whispered to me she didn't know how I made it to her chambers without a lawyer. I don't know.

I'm so happy to hear that you have legislation to increase inspections unannounced. I worked in a place and I know what management can do with announced inspections, and that was _____. It's like foster homes. I _____ through in-home care was bringing down costs and overhead for the state. For those of us who need more care, eight-hour shifts would be applied while in-home care are already, is well-established in elder abuse. Many cities have organized and are working independent of government funding, sharing questions with us about, questions to ask doctors, learning to read side effects of medication, teaching healthy food, encouraging exercise.

SENATOR ALQUIST: I also have a bill on adverse drug reactions to get medical personnel to report adverse drug reactions.

I want to thank you very much. We're going to close down in five minutes. I would love for everybody else to speak also.

MS. MANENTO: I do want to thank you. But most of all, when innovative, visionary, proactive men and women like yourselves are in office, with the Constitution, the Bill of Rights, and the dignity of America shines in America and around the world, and our children are pressed towards excellence with gratitude. Thank you.

SENATOR ALQUIST: Thank you for your beautiful comments. Thank you.

MR. PAUL TUTWILER: Senator Alquist, you're great.

My name is Paul Tutwiler, and I am a long-term care ombudsman from Santa Cruz County. I've been an ombudsman for seven-and-a-half years, volunteer ombudsman, and it's a retirement activity. I have been involved in nursing homes for 55 years. I remember the old days. I won't talk about

them now, things have changed; mostly for the better. Nevertheless, there is one particular issue I'm concerned about.

In my seven-and-a-half years' experience, I would say the greatest single problem, the greatest single source of complaints, substantiated complaints, by the way, is shortage of staff, the nursing shortage. And so I'm concerned with that issue. And I do sympathize with the fine people that I know who own and operate nursing homes. It's a hard job, and people work very hard in it. But realistically, I think that the most stringent means of accountability are needed. It's a real world.

So there is a provision in SB 526 that hasn't been really been mentioned about the electronic monitoring payroll. And while it's a simple thing, it is, I think, a realistic way of trying to approach the goal of accountability *now*. There will be studies how to do it better, but we want to do it now.

SENATOR ALQUIST: Thank you, Mr. Tutwiler. Are you related to Phyllis?

MR. TUTWILER: No. (Pause) Probably. (Laughter)

MS. TAMARA RASPBERRY: Senator, my name is Tamara Raspberry, and I am here on behalf of the Service Employees International Union, representing several thousand CNAs in nursing homes. So we thank you for the opportunity that we could finally could hear from those who work in the homes every day and taking their day off to come here and express to you some of their thoughts.

MS. NANCY EVANS: Hello, Senator. Thank you for hearing us today. My name is Nancy Evans, and I've been a CNA for 24 years, and I'm out of Concord, California. I've worked for hospitals; I've worked for private industry. But the nursing home is my heart, and I heard the lady and the gentleman that was in the wheelchair talk about the fear.

If I hear one of my residents say—you know what? If I say something, something's going to happen, I tell them, you tell me. For every one that says that I fear, I'm your spokesperson. I'm going to go out and

tell them how you fear because I got into this industry to help people. But due to the staffing that's been going downhill over the years—and I call it the *"AKA"* domino effect because staffing leads into other things from falls to, well, we can't take care of our patient. And I feel bad when I can't complete my job, you know. And I tell them, is that you're here in between these walls. But I hear your cries, and I want to take your cries out because we work really hard; we work really hard.

SENATOR ALQUIST: I had a wonderful CNA to taking care of my father, and I appreciate what you do.

MS. EVANS: And DHS needs to do their job because we have called upon them many, many times, and they don't want to do anything. They respond—I just heard a response that we got back in a letter. They find nothing. They find nothing adequate back about it, just like that lady said, and they're wrong; they're wrong. We're working it. They hide a lot of stuff, and we're there to see it. But I said, *"God sees all, and he's going to uncover."*

But I thank you for your help, and we need help with our staffing. Thank you.

SENATOR ALQUIST: Thank you.

If the other two ladies could just be very brief.

MS. KRISTINA SMAL: My name is Kristina Smal. I'm from Woodland, California, and I'm a CNA in a nursing home. And pretty much the staffing issues are a huge issue. I'm 21 years old, and I have a huge heart. But right now, I'd never see my grandpa go into a nursing home. If staffing issues were fixed, we could give them the quality of life that they've worked their whole life for.

SENATOR ALQUIST: I think there are some things that we can do to make the situation better. And there are some things that haven't been done that help make it worse. Thank you.

MS. RUTH SEGARRA: My name is Ruth Segarra. I work in the Jewish Home for the Aged. I've been there for 23 years.

SENATOR ALQUIST: Would you pull the mike closer to you?

MS. SEGARRA: Okay. My name is Ruth Segarra. This is my first time I'm talking for a public hearing.

UNIDENTIFIED SPEAKER: I can't hear you.

MS. SEGARRA: My name is Ruth Segarra. I'm a licensed vocational nurse in the Jewish Home for the Aged, one of the better nursing homes in California. We have problems with staffing. I've been a union activist in this facility. In my own particular nursing station, I am the only charge nurse with one CNA.

Through the years, the residents' health has declined, and I have been asking our assistant director of nurses, everybody from the bottom to the top to the CEO, to the Jewish Home lawyer, that this particular nursing station needs staffing. So we have several head injuries because I have asked all the heads that we need staff there. Falls could be prevented if we have adequate staffing in our units.

SENATOR ALQUIST: Thank you.

MS. SEGARRA: Thank you.

MS. DELORES C. CARLSON: My name is Delores Carlson. I'm an AARP member in Campbell, and that's where I found out you were having a meeting, so I'm thankful for that. I also have a mother in a nursing home. This is my first experience ever in a nursing home, and I really was very green. I had no idea what was going on _____ anything before anything else.

Basically, you're hearing all of these things. I also volunteer in nursing homes, and there are questions I have. I have no guidelines. I don't know what to look for most of the time_____ visitors program which _____ new program five years old.

Thank you for the information. But there are so many questions _____ nursing home. How much can you expect _____? There are some questions like you have, like, if I note _____ off day and find there's no staff around, and they said they were in the process of changing, shifting.

So there were just one or two people. And I thought shouldn't there be something in the interim.

SENATOR ALQUIST: This speaks to something we were taking about earlier, and how do you really find out, how do you really know what you really have? How does 3.2 hours per person, per patient day, how does that translate into the real world of _____?

MS. CARLSON: Well, there's a gap between shifts. I don't know why.

SENATOR ALQUIST: That's why we should quantify some of this. I'm going to be—we need to move forward.

MS. CARLSON: I have just one more _____.

SENATOR ALQUIST: One more.

MS. CARLSON: Okay. How do I find out where the 5 percent of the highest class of nursing homes are? My effort is for the future and for referring people.

SENATOR ALQUIST: Speak with Prescott Cole right here. Eventually, we're going to see that all of this information is on the website. It is not now, and my bill from 1999, which became law, said that documented violations of nursing homes were you to be posted on the internet. And $100,000 was given to that purpose, here at 2005, that still has not been done. So we are working on a solution. There are people you can speak to. Eventually though, sooner or later, you can see that there is a website where you can go to and you get answers to your question. So thank you very much.

I'm going to have to move forward. We have two more _____. One is standing up, and that would be Nancy Rutherford.

MS. NANCY RUTHERFORD: Yes, Senator Alquist. My name is Nancy Rutherford, and I've been an LVN 39 years. My family owned a very—they should model their nursing homes — it was Whitcomb, Irene Whitcomb in Palo Alto. They are now deceased, but she was on the premises. The reason they're having these problems, administrators come in these suits and everything, and they are not doing their job. When I go in, I'm it. I

come from a registry or I've been employed by them. You know, I'm in charge of these people. I don't know them. I'm very good at assessment skills, and you can assess the needs that staffing ratios are low. They have nurses' aides working 16 hours because those poor souls cannot meet their bills in the Bay Area. You know, I thank God that there is going to be a day of reckoning.

Who's ever running these, these are corporations. They are warehousing our elderly people. One of them I've worked in had people from a foreign country sleeping in bunk beds in a room. They bring them in. They don't speak English to these people. I mean I think it's appalling. I've worked for Kaiser 21 years _____ Burlingame 60 years where I grew up. I think my nursing skills are good. They just offered me two jobs in two nursing homes. One is at $19.50 an hour. I'm in charge of the whole ball of wax, then another one—oh, she wanted me to do 30 patients. You're it. I mean you're in charge of the medical, the nursing assistants. It's very hard. I recently went to get a childcare license. I cannot do it any more.

SENATOR ALQUIST: What is the main thing you would like for us to know?

MS. RUTHERFORD: They need to lobby. There is a law written. One to 87 patients, one person in assisted living. That is ludicrous. Those people have to go to the bathroom. They need to lobby and get these laws changed. From the licensing down, public health, these agencies need to be responsible. They are not responsible.

SENATOR ALQUIST: Thank you.

MS. RUTHERFORD: Thank you.

MS. RUTH GAY: Thank you, Senator. My name is Ruth Gay, and I'm with the Alzheimer's Association.

I'll be very brief. The thing that I wanted to say is when I heard from DHS those issues around all the reporting that goes on in the different segments and the issue that they do get reports that are hard to _____.

One of the things that I just want to say, is that working with families, and I've worked with many, many families who are moving, whether or not to report a case _____. What I find in the work that I do with people with Alzheimer's disease and their family members that are very reluctant to report. They're very fearful of reporting. You heard from some of the speakers here how they moved their mother when they file a complaint. Many people do not have the resources to do that. _____ Medi-Cal, it would be very difficult to move them from a facility _____.

So what I want to say is that they may be getting 14,000 reports a year, but that, I think, it's probably only a portion of what could have they do have where families try to move out of the facility, try to move out on their own, because they're fearful of retribution or they're fearful of _____. Thank you.

MS. ROSEMARY McCARTHY: I'm Rosemary McCarthy. My mother's been in a facility—several facilities—in Santa Clara County over the last several years.

I want to reiterate what so many people have said. I never met Mr. Goldsborough before, but I understood and I've seen that happen so often. Of course, the only difference is he was able to speak for himself.

I ended up spending the entire night with my mother because I was so concerned about her. I could not leave. The entire staff slept the entire night long. All those people that were working, I knew from working the day shift, they were good workers during the day, the night they were able to sleep. So one thing, I know we have limits on how many hours a trucker is allowed to work during the week. We need some sort of limits. These people pick up the extra shifts because they want the money. And the certain facilities have rules, so they go pick up another shift at another facility.

I have many other things to say, but I want to stick to that one because I didn't really hear them talk about that. Thank you.

SENATOR ALQUIST: Well, I want to thank all of you for being here, and particularly also those of you who are still here at ten minutes until 1:00 when we started at 9:30.

I think it's clear that there is a lot going on that is negatively affecting the positive quality of care in nursing homes. I think we've heard testimony that speaks to the Department of Health Services, and at many levels, one being how they're starting an appeals process, some of these pilot projects, including Alameda and San Jose, to other issues including not paying people what they need to be paid in order to do good work.

One reason I held this hearing was to talk about some of the accountability issues that we heard about today. And to do that, in regard to Mr. Frommer's bill, which was AB 1629, and why I carry my bill now, my Senate Bill, to deal with some of the issues. I was not in the Legislature during the two-year period when the Frommer bill became law. And quite bluntly, it allocates approximately $3 million over a three-year period of time affecting 1,400 nursing homes.

I'm not saying that we shouldn't see that we have money going into nursing homes, but what I'm definitely saying is that there are problems that need to be dealt with and we don't even really know what's really going on because DHS is not even looking into all of these issues.

I know that we need to see that staff of nursing homes, the staff is paid better. I know that nursing homes are faced with many constraints. But what I truly understand is that no one who's in a nursing home should live in fear of their life or their safety or their quality of care. And time upon time, witness upon witness, we have heard about how people have been afraid to come forward with complaints while their spouse or another loved one was in the nursing home. So, I think this has been a very good hearing.

It's one thing in hearings to look at problems. It's another thing to deal with the issues. And I do promise you I will for my constituents in Santa Clara County and those in the, really, in the entire state of California, that I will continue as chair of the Subcommittee on Aging to deal with these

specific issues to find out what DHS is doing. And just like my bill in 1999 required DHS to post document violations of nursing homes on the website, we will see that that is done very quickly. I know what it is like to have an elderly person that you love, and you certainly want to put them in a place where you believe, where you trust, *where you trust*, that they are going to get good care.

I believe that people want to do good, and I know we have many representatives from various entities dealing with this issue, and I do believe that we will be able to come together and deal with it and, when necessary, to have the course of law, the rule of law, to deal with situations where the elderly are not protected.

California—and this is my closing comment—California needs to be a place where it is a good place for seniors and the elderly to grow old. Thank you. (Applause)

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